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What predicts quality of the therapeutic alliance in a cognitive behavioural treatment for children with anxiety disorders? Therapeutic alliance measured from the patient, therapist and observer perspective

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Abstract

This study assessed the quality of the therapeutic alliance in a cognitive-behavioural treatment for anxious children, and examined possible predictors of the alliance. Participants were 20 clients diagnosed with an anxiety disorder. The therapeutic alliance was measured from the patient, therapist, and observer perspective early and late in therapy. Predictors included in the study were: 1) background predictors (gender, age condition, and treatment format); 2) parental style; 3) self-concept; 4) symptom severity; and 5) motivation and treatment credibility. Firstly, results showed that patients' and therapists' alliance ratings were high and similar, while observer-rated alliance was lower. Secondly, the correlation between patient-, therapist-, and observer-rated alliance varied. There was a significant correlation between patient- and therapist-rated early alliance. No correlation was found between observer-rated alliance and patient-rated alliance. Observer-rated and therapist-rated alliance was significantly correlated. Thirdly, the therapeutic alliance was stable over time for all the perspectives. Fourthly, predictors of the alliance varied for the different perspectives. Predictors of patient-rated alliance were mother-rated treatment credibility and self concept. Predictors of therapist-rated alliance were motivation, mother-rated treatment credibility, gender (girls were rated higher) and patient-rated treatment credibility. Predictors of observer-rated alliance were patient motivation and an autonomous parental style.

Sammendrag

Denne studien vurderte kvaliteten på den terapeutiske alliansen i en kognitiv adferdsterapi for engstelige barn, og undersøkte mulige prediktorer for allianse. Deltakerne var 20 klienter diagnostisert med en angstlidelse. Den terapeutiske alliansen ble målt fra pasient-, terapeut- og observatør perspektivet tidlig og sent i terapi. Prediktorer inkludert i studien var: 1) bakgrunnsvariabler (kjønn, aldersbetingelse og behandlingsformat); 2) foreldrestil; 3) selvbilde; 4) symptombelastning; og 5) motivasjon og behandlingstiltro. For det første viste resultatene at pasientenes og terapeutenes alliansebedømninger var høye og tilnærmet like, mens observatørbedømt allianse var lavere. For det andre varierte korrelasjonene mellom pasient-, terapeut- og observatørbedømt allianse. Det var en signifikant korrelasjon mellom pasientbedømt og terapeutbedømt tidlig allianse. Det var ingen korrelasjon mellom observatørbedømt og pasientbedømt allianse. Observatørbedømt og terapeutbedømt allianse var signifikant korrelert. For det tredje var den terapeutiske alliansen stabil over tid for alle perspektivene. For det fjerde varierte prediktorene for allianse for de ulike perspektivene. Prediktorer for pasientbedømt allianse var mors behandlingstiltro og pasientens selvbilde. Prediktorer for terapeutbedømt allianse var pasientens motivasjon, mors behandlingstiltro, kjønn (jenter ble bedømt høyere) og pasientens behandlingstiltro. Prediktorer for observatørbedømt allianse var pasientens motivasjon og en autonom foreldrestil.

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Introduction

Although research has demonstrated that cognitive-behavioural treatment (CBT) for children and youth with anxiety disorders is effective (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Compton et al., 2004; James, Soler, & Weatherall, 2005), there has been a recent focus on how to better understand why treatment works (Green, 2006; Karver, Handelsman, Fields, & Bickman, 2005; Kazdin & Nock, 2003; Weisz, 2000). The therapeutic alliance has for many years been viewed as an important change mechanism in adult psychotherapy (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). This holds across a diversity of treatment orientations, which highlights the therapeutic alliance as a nonspecific factor which is important regardless of theoretical preference (Horvath & Symonds, 1991; Martin et al., 2000).

More recently youth psychotherapy research has also been concerned with process factors. The two meta-analyses which have been conducted on the therapeutic alliance for patients 18 years and younger found an alliance-outcome association of $r = .24$ (Shirk & Karver, 2003) and of $r = .26$ (Karver et al., 2006), which are small to medium effect sizes.

Despite the evident importance of the therapeutic alliance, research assessing the role of alliance in treatment of children and youth with anxiety disorders is minimal and represents an important gap in the field (Liber et al., in press). Increased knowledge about the therapeutic alliance, the role it plays in treatment of anxious children, and factors contributing to the development of the therapeutic alliance will enable us to tailor interventions in ways that enhance the alliance. The aim of the current study is to assess the quality of the therapeutic alliance in a CBT treatment for anxious children, and examine potential predictors of the alliance.

Definition of the therapeutic alliance

Definitions of the therapeutic alliance have been differently worded by investigators (e.g.Bordin, 1979; DiGiuseppe, Linscott, & Jilton, 1996; Luborsky, 1994). In the adult literature, a conceptualization that contains the following components is common: goal of therapy agreed upon by patient and therapist, tasks agreed upon, and an emotional/personal bond between patient and therapist. The child alliance research has been lacking an unifying definition of the therapeutic alliance (Chu et al., 2004; Shirk & Karver, 2003). It has been suggested that the three basic dimensions of bond, task, and goal found in the adult alliance research are applicable to child psychotherapy (Smith-Acuna, Durlak, & Karpar, 1991). Others have identified a bond and a task factor, but have failed to find a separate goal dimension (McLeod & Weisz, 2005; Shirk & Saiz, 1992). Thus, the definition of the therapeutic alliance in child psychotherapy is unclear, which indicates a need of further research that measures alliance from different perspectives, development of the alliance over time, and factors that are correlated with the alliance.

Childhood anxiety disorders

This particular study will examine a sample of children and youth diagnosed with anxiety who are being treated with CBT, which represent an empirically validated efficient treatment for anxiety disorders (Compton et al., 2004). Anxiety disorders in children and youth are relatively common. In a Norwegian sample of 8-10 year old children over 3 percent were found to have an anxiety disorder (Heiervang et al., 2007). This is comparable to the prevalence of anxiety disorders found in a study in Great Britain (Heiervang, Goodman, & Goodman, 2008).

Anxiety disorders can lead to considerable distress and interference for children and their families. For instance, avoidance of certain social activities can impede normal social development and lead to peer rejection. Decline in school performance and disinterest in age-appropriate social activities have also been indicated (Ollendick & Hirschfeld-Becker, 2002). Moreover, excessive worry and anxiety might lead to low self-worth (Fordham & Stevenson-Hinde, 1999) and attention problems (Kendall & Pimentel, 2003). The Norwegian authorities have therefore targeted anxiety disorders as a prioritized disorder demanding treatment (Helse Vest RHR, 2008).

Quality of the therapeutic alliance rated from different perspectives

To our knowledge, three studies have been conducted on the therapeutic alliance in CBT treatment for children where anxiety is the primary disorder (Kendall, 1994; Kendall et al., 1997; Liber et al., in press). Two of the studies used self-report measures of alliance (Kendall, 1994; Kendall et al., 1997). In these studies the quality of the alliance was rated highly by the children. The third study used an observational measure of the alliance. From an observer perspective the therapeutic alliance was also rated highly (Liber et al., in press). The therapists' perceptions of the alliance were not included in these studies. From the adult literature we know that patients generally rate the alliance higher than therapists (e.g., Bachelor & Salamé, 2000).

Therapists, patients, and observers have different perspectives of the alliance, and it is therefore beneficial for research to include multiple perspectives of the alliance (Creed & Kendall, 2005). Some studies have found no significant relationship between child and therapist rated alliance (Shirk & Saiz, 1992; Smith-Acuna et al., 1991). However, one study found a significant positive correlation between child, therapist,

and observer ratings of the alliance (Creed & Kendall, 2005). In the adult literature there has been found poor convergence of therapist and patient perceptions of the relationship characteristics, regardless of assessment time (Golden & Robbins, 1990; Horvath & Marx, 1990; Piper, Boroto, Joyce, McCallum, & Azim, 1995; Tichenor & Hill, 1989).

In child psychotherapy research, the patients' and therapists' subjective experiences of the alliance are most commonly assessed (Shirk & Saiz, 1992; Smith-Acuna et al., 1991). This subjective perspective of the alliance gives important information about the alliance, but child therapy research also needs process scales that can be used by objective observers (Estrada & Russel, 1999). Developmental constraint, like memory, language, attention or concentration, can limit the child's abilities to report from their experiences of therapy (Estrada & Russel, 1999; Shirk & Kraver, 2003). Child self report of the alliance might also reflect a wish for saying nice things about the therapist or that children answer what they believe is expected (demand characteristics; Shirk & Kraver, 2003). Because of these possible limitations, a supplement of direct observation is beneficial. Consequently, the current study will include an observational measure, the Therapy Process Observational System-Alliance Scale (TPOCS-A; McLeod, 2001) in addition to self report from both the child and the therapist. The observational measure TPOCS-A was also employed in the study by Liber et al. (in press).

Development of the therapeutic alliance over time

To date, little knowledge exists of the developmental course of the alliance with children and youth, including how it develops or changes over time (Zack, Castonguay, & Boswell, 2007). This is also true for the adult alliance literature (Castonguay,

Constantino, & Holtforth, 2006). A stable alliance would presumably have other clinical implications than an alliance that varies with therapeutic challenges. Increased knowledge about the development of the alliance over time would therefore be of interest to clinicians and researchers. So far, most of the alliance literature concludes that the therapeutic alliance is established early (Bachelor & Salamé, 2000; Greenberg, 1994; Martin, Garske, & Davis, 2000). Some researchers, however, have proposed that the alliance varies with the challenges of therapy (Gelso & Carter, 1994; Horvath, Gaston, & Luborsky, 1993; Luborsky, 1976).

The therapeutic alliance in anxious children and youth

In samples of children diagnosed with anxiety the findings regarding the alliance-outcome link is mixed (Kendall 1994; Kendall et al., 1997; Liber et al., in press). Two clinical trials found no significant associations between alliance and outcome in CBT treatment for children diagnosed with anxiety (Kendall, 1994; Kendall et al., 1997). Counter to these studies Liber et al. (in press) found that a stronger child alliance was associated with more reliable change, a measure that considers the standard deviations and reliability of the original measure, thus reducing measurement error (Jacobsen & Truax, 1991). However, the studies by Kendall (1994; Kendall et al., 1997) and Liber et al. (in press) used different methods of measuring the alliance. Kendall (1994; 1997) used a self report measure of the alliance, while Liber et al. (in press) used an observational measure (TPOCS-A).

The studies referred to above point to uncertainty about the importance of the alliance in therapy for anxious children. However, in a 3-year follow-up study to Kendall (1994), a free-recall interview showed that former child patients reported the

therapeutic alliance as the “most important” treatment factor 44 % of the time. The importance of the therapeutic alliance was reported more frequently than “dealing with fears and problems” (39 %), “games and activities” (19%), and “in vivo exposures” (17%) (Kendall & Southam-Gerow, 1996). Thus, from the child perspective the therapeutic alliance was viewed as highly important.

Furthermore, compared to youth with internalizing disorders a stronger alliance-outcome relation has been found for youth with externalizing disorders, possibly due to the greater challenges of forming an alliance with children that are more hostile (Shirk & Kraver, 2003). This is comparable to findings within adult samples, which have shown that patient hostility predicts alliance difficulties (Horvath & Luborsky, 1993). Considering these data, we might expect fewer challenges forming a therapeutic alliance in our sample of patients with an internalizing disorder.

Also, it needs to be considered that child therapy poses additional challenges to the alliance formation compared to adult alliance. Children may be brought to treatment by parents or outsiders for problems that they believe do not require treatment, do not exist, or cannot be controlled (DiGiuseppe et al., 1996; Shirk & Russell, 1996). Adolescents may have a need for autonomy and a distrust of adult authority which may influence the alliance (DiGiuseppe et al., 1996; Steinberg, 1990).

Clinicians have described the establishment of the therapeutic alliance as a major task in youth psychotherapy (Binder, Holgersen, & Nilsen, 2008). Both researchers and clinicians suggest that the client-therapist alliance is a factor that needs empirical attention in child therapy (Kazdin, Siegel, & Bass, 1990; Shirk & Saiz, 1992). The focus of the current study will be on factors that predict alliance. With increased knowledge

about the therapeutic alliance we may also be able to know more about the role alliance plays in the outcome for anxious children.

Predictors of the therapeutic alliance

Without a better understanding of factors contributing to the development of quality alliance, findings relating alliance to outcome will be of limited use to therapists (Constantino, Arnow, Blasey, & Agras, 2005; Norcross, 2002).Thus, it is important to identify factors that are associated with the alliance so that therapists can be more aware of potential relationship ruptures and alter their interventions accordingly (Muran, Segal, Samstag, & Crawford, 1994; Safran, Muran, Samstag, & Stevens, 2001). Predictors included in the current study are: 1) background predictors (gender, age condition, and treatment format); 2) parental style; 3) self-concept; 4) symptom severity; and 5) motivation and belief in therapy.

Background predictors. Gibbons et al. (2003) found that gender significantly predicted the therapeutic alliance, specifically that females formed a more positive therapeutic alliance with their therapist.

Another possible background predictor is the patient age. Social cognitive theory suggests that self-evaluative and attribution styles are important for development of quality alliance (DeVet, Kim, & Chrlot-Swilley, 2003). If a child doesn't see him or herself as in need for help, the child may be less willing to enter into therapy. As children mature they may develop more insight into their need for change (Shirk & Saiz, 1992). On the other hand, the developmental trend toward increased independence from authority figures may decrease the likelihood for a positive alliance for older children (DiGiuseppe et al., 1996). One study hypothesised that older children would be

more likely to report a better alliance compared to younger children, but found the opposite (DeVet et al., 2003).

A third background predictor included in the study is treatment format. It has been found that children with a strong alliance in individual treatment are more likely to be without a diagnosis at treatment termination, compared to children with a strong alliance in group treatment (Liber et al., in press). This indicates that a strong alliance is more important in promoting recovery in individual treatment, compared to group treatment (Liber et al., in press). It might be that other treatment processes, such as group cohesion is more important compared to the patient-therapist alliance in group treatment (Liber et al., in press). The relationships that form cohesion in a group include: 1) patient to group, 2) patient to patient, and 3) patient to therapist (Burlingame, Fuhriman, & Johnson, 2002). In adult samples group cohesion has been linked to treatment response and completion in group treatment (Hilbert et al., 2007). However this has not been found in CBT group treatment for youth (Kaufman, Rohde, Seeley, Clarke, & Stice, 2005). More studies are thus needed to clarify the potential role of therapeutic alliance in group versus individual treatment.

Parental style. Another possible predictor of the therapeutic alliance is parental style. The therapeutic alliance involves elements of emotional intimacy and supportive caregiving. It is therefore possible that the patients' experience of their parents' parental style will influence how they relate to their therapist. Attachment theory suggests that early attachment history influences the ability to enter into relationships (DeVet et al., 2003). In line with this perspective, children's positive relationship with parents produces favourable expectation for other relationships, whereas an adverse parent-child relationship produces negative expectations for other relationships (Shirk & Saiz, 1992).

Children's perceptions of closeness with their therapist have been found to be associated with their perception of closeness with their mothers (DeVet et al., 2003). From the adult literature, it has been found that clients' bond with fathers was a significant predictor of therapist rated therapeutic alliance. However, patient report of early parental bond was not significantly correlated with patient rated therapeutic alliance (Mallinckrodt, 1991). The possible association between perceived parental style and therapeutic alliance is therefore worth further investigation.

Motivation and treatment credibility. Other factors that might influence the therapeutic alliance are motivation and belief in therapy. Patient motivation for treatment is considered to be essential to the progress and outcome in therapy (e.g., Keijser, Schaap, Hoogduin, Hoogsteyns, & Kemp, 1999). Patients who enter treatment with more hope about the therapeutic process may be more motivated to engage interpersonally with the therapist, whereas those who are pessimistic about the value of psychotherapy might be more likely to stay interpersonally distant (Gibbons et al., 2003).

In CBT, several researches have defined motivation as a state of readiness for change before the introduction of treatment interventions (Dean, 1958; Keijser et al., 1999). This definition includes patients' acknowledgment of having problems, commitment for change, and credibility or belief in therapy (e.g., Kanfer & Grimm, 1980).

According to goal theories, people will work toward a goal as long as they expect that the goal can eventually be reached (Austin & Vancouver, 1996). Without such positive expectation, the person is likely to become discouraged and to disengage from pursuing the goal. In line with this perspective, Gibbons et al. (2003) found that

patients' pre-treatment expectation of improvement predicted patient-rated early alliance quality in supportive-expressive therapy, as well as patient-rated middle alliance quality across both supportive-expressive and cognitive therapy. In addition, it has been found that patients' pre-treatment rating of expected improvement significantly predicted patient- and therapist rated alliance quality (aggregated across all sessions) in time limited therapy (Joyce, Ogrodniczuk, Piper, & McCallum, 2003).

From the child literature, Estrada & Russell (1999) found moderate correlations between child motivation and therapeutic alliance. A distinct challenge in child psychotherapy is that most youth and child patients are referred to mental health by a third-party (Taylor, Adelman, & Kaser-Boyd, 1985). This may influence patients' motivation and willingness to participate in therapy. Results from the study by Taylor et al. (1985) found that youth patients had negative attitudes toward treatment and did not see themselves as in need of help. However, evidence exists to indicate that the characterization of adolescents as unmotivated for treatment may have been overemphasized, and that they do acknowledge their need for treatment (Garland, Lewczyk-Boxmeyer, Gabayan, & Hawley, 2004). In this study, we will explore the association between motivation, treatment credibility, and therapeutic alliance. Mothers' ratings of treatment credibility will also be included because of the roles of parents in both initiating and terminating child treatment.

Self concept. To our knowledge no study to date has assessed the relationship between self concept and the therapeutic alliance. There may be an association between the therapeutic alliance and youth's feelings of confidence and belief in their ability to influence their world, which warrants the exploration of possible links between self concept and alliance.

Symptom severity. One might also expect a relation between pre-treatment symptoms and the therapeutic alliance. Patients who are very symptomatic may be more discouraged and less able to engage with the therapist during treatment. Alternatively, those with more symptoms might have greater motivation to engage in treatment to be relieved of their distress (Gibbons et al., 2003). The research findings have been mixed regarding the relation between levels of pre-treatment symptoms and the therapeutic alliance (Horvath & Bedi, 2002). Gibbons et al. (2003) found in their study that pre-treatment level of symptoms was not a significant predictor of the therapeutic alliance. Others have found the severity of symptoms to be a weak predictor (Hersoug, Monsen, Havik, & Høglend, 2002). In the study by Hersoug et al. (2002), patient rated therapeutic alliance was uncorrelated with symptom severity. However, therapist rated therapeutic alliance was correlated with symptom severity, where therapists tended to rate the alliance higher for patients with less symptoms. The previous mixed results indicate a need for further research into the role of symptom severity for alliance formation.

The context of this study

This study is part of the research project "Assessment and treatment - anxiety in children and adults", funded by Western Norway Regional Health Authorities (Helse Vest RHR, 2008). The main study examines the effect of CBT for anxiety disorders in children and adults. The child part of the study targets children (8-12 years) and adolescents (12-15 years) with separation anxiety, social phobia, and/or generalized anxiety disorder. The participants are randomized to one of three treatment conditions: group CBT, individual CBT, or a 5-week waiting list. The treatment programme is

"Friends for life" (FRIENDS), a cognitive behavioural programme with 10 weekly sessions and two booster sessions. FRIENDS is manual-based, and approved Norwegian translations of the manuals were used. There are separate manuals for children (aged 8-12) and adolescents (aged 12-15) with similar contents presented in age-appropriate language. FRIENDS is based on a theoretical model which addresses cognitive, physiological, and behavioural processes that are seen to act together in the development, maintenance and experience of anxiety (Barrett, 2007). The letters FRIENDS represent an acronym for the strategies taught in the program. F is for "feelings", focusing on awareness and recognition of the feelings of self and others. R is for "relax and feel good" and is about learning relaxation techniques. I stands for "inner thoughts" and is about recognizing how thoughts influence feelings and behaviour. E is for "explore step plans", where children and families learn to gradually approach goals they have set. This is the exposure part of the programme. N is for "nice work so reward yourself" and focuses on the role of rewards for efforts. D is for "don't forget to practice" and is a reminder that skills learned in the programme need to be rehearsed. S is for "stay calm, you know how to cope now" which also reflects the general positive focus on resilience that the programme represents (Shortt, Barrett, & Fox, 2001). Parents participate in one full session and at the end of each session. Additionally, parents are expected to attend two parent evenings.

The child study takes place in seven child and adolescent mental health clinics within the Western Norway Health Authorities. The sample of the current study is taken from the pilot study, which took place in 2007. The aim of the pilot study was to give therapists more experience in using the FRIENDS manual, as well as to settle routines for data collection.

Research questions. The research questions in this study are:

1) How is the quality of the therapeutic alliance in a CBT treatment (FRIENDS) for children with anxiety disorders rated by children, therapists, and observers?

2) What is the connection between patient-, therapist-, and observer- rated therapeutic alliance?

3) How stable is the therapeutic alliance from early to late in treatment?

4) Which factors can be found to predict the therapeutic alliance?

Method

Participants

Child participants. Our sample was drawn from the FRIENDS pilot study, which totally comprised 50 children treated at six outpatient child- and adolescent mental health clinics in Western Norway. Children in the pilot study were regular clients referred to the clinic. Inclusion criteria for the pilot study were anxiety diagnosis or considerable anxiety symptoms. Exclusion criteria were pervasive developmental disorder, severe behaviour problems, severe attention deficit hyperactivity disorder, or IQ below 70. Allocation of subjects to group or individual treatment was determined by the capacity of each clinic. If the clinic had a sufficient number of patients to form a group at the start of treatment, they conducted a group treatment. If the number of suitable patients was lower, the therapists invited available clients to individual treatment. The requirements for therapists to be approved for the main study were to conduct at least two individual treatments and one group treatment.

In the current study, subjects from whom data material was sufficient, and where audible videotapes were available were included. Consequently, our study comprised 20

participants drawn from four clinics. In our sample, six patients received individual treatment, and 14 received group treatment. Ten participants were treated using the child manual (for ages 8-12) and ten using the youth manual (for ages 12-15). Mean age for the sample was 12.1 (SD = 1.99, range 9-15). Nine patients were boys and 11 were girls.

The patients were diagnosed with separation anxiety disorder (SAD), social phobia (SOP), or generalized anxiety disorder (GAD). Three patients had all three diagnoses. Seven patients had two diagnoses and ten patients had only one diagnosis. Out of these, four had SOP, four had SAD, and two had GAD. Table 1 provides a description of the sample including diagnosis details.

Participating therapists. Two therapists from each clinic, altogether eight females, participated in the study. Their age ranged from 30 to 59. Their therapeutic experience ranged from three to 19 years. One therapist was a psychologist specializing in clinical child and adolescent mental health, three were specialist child and adolescent psychologists, and four were clinical pedagogues. One of the specialist psychologists also had two years of training as a cognitive therapist. The therapists received regular in person and telephone supervision by two experienced FRIENDS therapists.

Observers rating therapeutic alliance. There were three observers of alliance, two graduate female psychology students and one male psychologist. Observers were 26, 32 and 40 years of age. The students had two years of part time clinical experience, one with adults only, the other one with adults and children. The psychologist had five years of clinical experience, mainly with children. He is also a Ph-candidate in the ongoing FRIENDS project, and is supervising some of the participating therapists. None of his supervisees were part of this particular study. The two students received two days

of training in administration of the FRIENDS manual, which is the official Norwegian FRIENDS-training programme. The psychologist had been trained in FRIENDS by Paula Barrett, and worked with her in Australia for 4 months.

Procedures

The Therapeutic Process Observational Coding System – Alliance Scale (TPOCS-A; McLeod, 2001), developed by Dr. Bryce McLeod at Virginia Commonwealth University, was used when rating the videotaped sessions.

Observer training. All observers received training in use of the TPOCS-A scoring form, according to the TPOCS-A manual (McLeod, 2001). One of the observers translated the form into Norwegian and two observers translated this version back into English. The backtranslated version was approved by Dr. McLeod. McLeod provided us with 21 videos from the Youth Anxiety and Depression Study (YADS; Weisz, 2004) for training purposes. The observers used the YADS-videos to train for interrater reliability over a period of one month. Our individual scores were compared to Dr. McLeod's expert scores, as well as with each others' scores.

The criteria of Ciccetti and Sparrow (1981) state that an interrater reliability of less than .40 is of poor clinical significance, while .40-.59 is fair, .60-.74 is good, and above .75 is excellent. After scoring 21 training videos the mean interrater reliability for all scores on all items was good (.74). The interrater reliability was excellent for six items, good for two items and poor for one item. Table 2 provides information on interrater reliability. The item on which we achieved poor interrater reliability was Bond 2, which concerns hostility shown toward the therapist ("To what extent did the client act in a hostile, critical or defensive way toward the therapist?"). The low reliability

score was understood as due to very little variation between observers. According to personal communication with Dr. McLeod, such low variation will negatively affect interrater reliability scores (McLeod, e-mail, October 28th, 2008). This item was nearly always rated as "0" by all raters. There was no surprise that anxious children showed little hostility toward their therapists. In agreement with Dr. McLeod, we therefore decided to proceed scoring the FRIENDS pilot videos in spite of low reliability on one item.

Scoring of FRIENDS pilot therapy sessions. In total, we rated 40 complete pilot videos. Group sessions lasted 90 minutes, and individual sessions 60 minutes. For each child, we watched one early (sessions 2-4) and one late session (sessions 6-9). Most group videos were watched once, but four group videos were watched twice, and three were watched three times. However, when this was done, we focused on a different child, and made sure the repeated videos were spread out in time.

All videos were triple coded. Regular coder meetings were conducted to prevent coder drift. During coding we were separated by light walls to prevent non-verbal contact. No verbal contact was made. In analyses, the mean score for the three scorers was used. According to Lambert & Hill (1994), mean scores, as opposed to scores produced by one coder only, reduce measurement error by removing differences among coders. Interrater reliability for the scoring of 40 FRIENDS pilot videos was calculated and the mean interrater reliability for all scores on all items was good (.71). The interrater reliability was excellent for four items, good for three items and fair for two items, according to the criteria of Ciccetti and Sparrow (1981). Table 2 provides details on interrater reliability.

Ethics

The study was approved by the Regional Ethical Committee (REK Vest) and Norwegian Social Science Data Services (NSD). Parent, child, and therapist participants were informed that the sessions would be videotaped, and that the content would be available for research purposes. All participants signed forms of informed consent, stating their willingness to participate on these conditions. See Appendix A for NSD letter and Appendixes C-F for forms of informed consent.

Measures

Assessment of diagnosis. Diagnostic assessment was based on the Anxiety Disorders Interview Schedule Child and Parent version (ADIS-C/P; Silverman & Albano, 1996). ADIS-C/P is shown to be a reliable instrument (Silverman, Saavedra, & Pina, 2001).

Assessment of parental style. General parental style was assessed by the Rearing Behaviour Questionnaire (RBQ; Bögels & Melick). The RBQ measures three dimensions of parental style: 1) autonomy versus overprotection, 2) acceptance versus rejection, and 3) control versus regulation (Bögels & Melick, 2004). The internal consistency of the RBQ is shown to be good (Guerra & Braungart-Rieker, 1999; Siqueland, Kendall, & Steinberg, 1996). In this study, the inter-item reliability was good for the dimensions psychological control ($\alpha = .89$) and overprotection and acceptance versus rejection ($\alpha = .83$), and acceptable for the dimension autonomy versus encouragement ($\alpha = .67$). The RBQ form is provided in Appendix G.

Assessment of self concept. The Self Concept Scale (SCS; Beck, Steer, & Epstein, 1992) was used to assess participant's self concept. This is a 20-item self-report

measure. In the current study the inter-item reliability was good (α = .93). The SCS form is provided in Appendix H.

Assessment of symptom severity. To assess client's symptom severity, Spence Children's Anxiety Scale (SCAS) was used. This is a 44-item self-report measure that assesses symptoms relating to separation anxiety, social phobia, obsessive-compulsive disorders, panic-agoraphobia, generalized anxiety and fears of physical injury (Spence, 1998). The internal consistency of the total score and subscales has been found to be high (Spence, 1998). In this study the inter-item reliability was good (α = .84). The SCAS form is provided in Appendix I.

A second measure of symptom severity was the Children's Automatic Thoughts Scale (CATS). The CATS is a 40-item self-report measure designed to assess a wide range of negative self-statements in children and adolescents. The internal consistency of the total score and subscales has been shown to be high and test-retest reliability at 1 and 3 months to be acceptable (Schniering & Rapee, 2002). In the current study the inter-item reliability was good (α = .95). The CATS form is provided in Appendix J.

Assessment of motivation and credibility of treatment. To assess participant's motivation for psychotherapy the Nijmejgen Motivational List (NML) was used. This is a 12-item self-report measure, were 5 items constitute the factor "willingness to participate", 3 items the factor "level of distress", and 3 items the factor "pressure from others" (Keijser et al., 1999). The internal consistencies and re-test reliabilities of the factors have been found to be reasonable (Keijser et al., 1999). In this study the inter-item reliability was good (α = .80). The NML form is provided in Appendix K.

The Credibility Scale (CS; Bokovec & Nau, 1972) was used to assess the credibility of the treatment, rated by both patients and mothers. This is a 4-item self-

report measure. In the current study the inter-item reliability was good for the patient form (α =.84) and for the mother form (α = .89). The CS forms are provided in Appendix L.

Assessment of therapeutic alliance. The Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992) was used to assess child/youth and therapist view of the therapeutic alliance. TASC is an 8-item self-report measure that assesses child affect toward the therapist (7 items) and child agreement with therapist regarding tasks of therapy (1 item). TASC has demonstrated excellent reliability and validity (Shirk & Saiz, 1992). In this study the inter-item reliability was good for the patient form (α = .95 for the full sample, α = .79 for early alliance, and α = .86 for late alliance), as well as for the therapist form (α = .74 for the full sample, α = .89 for early alliance, and α = .92 for late alliance). Negatively worded questions (items 2, 5, 8 and 11) were reversed before data analysis. The TASC forms are provided in Appendix M.

The Therapy Process Observational Coding System – Alliance scale (TPOCS-A; McLeod, 2001) was used by observers to assess the child-therapist alliance. The TPOCS-A is a 9-item observational measure used by observers to assess the bond between the client and therapist (6 items), and the therapeutic tasks (3 items). According to McLeod and Weisz (2005), the TPOSC-A has a good internal consistency (α = .95 for the full sample, α = .93 for early alliance, and α = .91 for late alliance). In the current study the inter-item reliability was good (α = .76 for the full sample, α = .89 for early alliance, and α = .91 for late alliance). Negatively worded items (bond items 2, 5, and 6, and task item 2) were reversed before data analysis. The TPOCS-A form is provided in Appendix N.

Results

When analyzing the data we first conducted independent samples t-tests to check for gender, age, and format differences for the measures included in the study. Secondly, we calculated means and standard deviations of the alliance scores, as well as percentages of the maximum obtainable score for each alliance scale. Thirdly, correlation analyses between potential predictor variables and therapeutic alliance were calculated. Before computing the correlation analyses we checked and found no outliers or curvilinear relations. Finally, multiple regression analyses were conducted for the potential predictors which were significantly correlated with one or more alliance rating(s). An exception was treatment format, which was included in the multiple regression models if mother-rated treatment credibility was included. This was done to check if treatment format was a mediator ("third variable"). Multiple regression analyses were conducted in spite of the low number of participants, as this is an exploratory study.

Independent samples t-test checking for gender, age or format differences

Mother-rated treatment credibility was significantly higher in individual treatment compared to group treatment. Early and average patient-rated alliance, early therapist-rated alliance, and late and average observer-rated alliance were all significantly higher in individual treatment. Late therapist-rated alliance was significantly higher for girls compared to boys. On the dimension acceptance versus rejection of the RBQ youth scored significantly lower compared to children. The fact that adolescents experienced lower acceptance from their parents compared to younger

children came as no surprise, as adolescence represents a natural period of more turmoil in parent-child relations. We therefore proceeded analyzing this factor.

There were no significant gender, age, or format differences for the other measures included in the study. Overviews of the independent samples t-tests are provided in Tables 3, 4, and 5.

Quality of the therapeutic alliance rated from different perspectives

Patients' and therapists' average ratings of the alliance were similar and high. Observer-rated alliance was on average lower than both patients' and therapists' ratings of the alliance. The quality of the alliance was determined by calculating the percentage of the maximum obtainable score for each alliance scale. Direct comparison of patient/therapist- and observer-rated alliance were not possible due to different scale ranges. An overview of patient-, therapist-, and observer-rated early, late, and average alliance, as well as percentage of total alliance-scores is provided in Table 6.

The TPOCS-A also includes 4 items that measure the observers' judgement of the session, which are: 1. "To what degree do you think this was a good session?", 2. "How involved were you in watching the videotape?", 3. "How much did you personally like the therapist in this session?", and 4. "How much did you personally like the client in this session?". Analyses showed that 1) the four questions were significantly correlated, 2) the ratings of these four questions were significantly correlated with alliance ratings, and 3) there were no systematic differences between how the three observers answered the four questions. The relationship between these four questions and the alliance is not included in the scope of this assignment.

Correlations between alliance scores rated by patient, therapist and observer

The correlations between patient-rated alliance and therapist-rated alliance were low to moderate for early alliance, and uncorrelated for late and average alliance. There were no correlations between patient-rated alliance and observer-rated alliance neither early nor late in therapy. The correlations between therapist-rated and observer-rated alliance were moderate. The correlations between early alliance and late alliance were strong for patients and moderate for therapists and observers, and point to a stable alliance across time. Correlations between early, late, and average alliance from the patient-, therapist-, and observer-perspective, as well as correlations between these perspectives, are provided in Table 7. An overview of correlations between predictor variables and the different alliance ratings is provided in Table 8. In the following section, results from correlation and multiple regression analysis will be presented subsequently from the perspectives of patients, therapists, and observers.

Patients' ratings of the therapeutic alliance

Correlations. Treatment format was significantly correlated with early and average alliance scores from the patient perspective. Individual treatment was associated with higher early and average alliance scores compared to group treatment. Higher ratings on the self concept scale was related to higher late and average therapeutic alliance. There was a significant positive correlation between mother-rated treatment credibility and therapeutic alliance rated by patients early, late, and on average.

Multiple regressions. An overview of the multiple regression models from the patient perspective is provided in Table 9. The multiple regression models were

significant both early and late in therapy and for average alliance. Treatment format was not predictive of alliance. Mother-rated treatment credibility was predictive of early, late and average alliance. Self concept ratings were predictive of alliance late in therapy.

Therapists' ratings of the therapeutic alliance

Correlations. Patient gender was significantly correlated to therapist ratings of late alliance. Therapists reported higher therapeutic alliance to girls compared to boys. Treatment format was significantly correlated to therapist ratings of early alliance. Alliance was rated higher in individual treatment compared to group treatment. Patients' scores on the symptom scale (SCAS), were positively correlated to therapists' early alliance ratings. Also, patients' negative automatic thoughts scores on the CATS were positively correlated with therapists' early and average alliance ratings. Patient motivation was positively correlated to early and average therapist alliance ratings. In addition, patient-rated treatment credibility was positively related to late and average therapist alliance ratings, and mother-rated treatment credibility was positively related to early therapist alliance ratings.

Multiple regressions. An overview of the multiple regression models from the therapist perspective is provided in Table 10. The multiple regression models were significant early and late in therapy, but not for average alliance. Neither treatment format nor anxiety symptoms were predictive of therapist alliance ratings early in therapy. Patients' reports of negative automatic thoughts were not predictive of early or average therapist-rated alliance. Patients' motivation was predictive of early therapist alliance, and mother-rated treatment credibility was predictive of early and average therapist alliance. Further, patient-rated treatment credibility predicted alliance late in

therapy. Gender was predictive of alliance late in therapy, where girls were rated to have a better alliance than boys.

Observers' ratings of the therapeutic alliance

Correlations. Treatment format was significantly correlated with late and average alliance scores from the observer perspective. Alliance was rated higher in individual treatment compared to group treatment. An autonomous parental style was related to higher late and average alliance ratings. Further, patient motivation was positively correlated to early observer-rated alliance.

Multiple regressions. An overview of the multiple regression models from the observer perspective is provided in Table 11. The multiple regression models were significant both early and late in therapy, and for average alliance. Patient motivation was predictive of early alliance, and an autonomous parental style was predictive of late and average alliance. Treatment format was not a significant predictor of late and average alliance.

Comparing the results across participant perspectives

Correlations. When comparing the results of the correlation analysis for patient, therapist, and observer perspectives, there are no findings which are similar to all three perspectives. When comparing the results of patient- and therapist-rated alliance, individual treatment was positively related to early alliance for both perspectives. Furthermore, mother-rated treatment credibility was positively correlated to both therapists' and patients' ratings of early and average alliance. When comparing the results of patient- and observer-rated alliance, the only similar findings across the

perspectives were that individual treatment was positively related to average alliance. When comparing the results of therapist- and observer-rated alliance, the similar finding was that patient motivation was positively related to early alliance.

Multiple regressions. When comparing the results of the multiple regressions we found no predictors which were similar across all three perspectives. Mother-rated treatment credibility was predictive of early alliance from both a patient and a therapist perspective. The other predictors were different for the various perspectives.

Discussion

The primary aim of the present study was to examine what predicts quality of the therapeutic alliance in a CBT treatment (FRIENDS) for children with anxiety disorders. We found no significant predictors which were similar across all three perspectives of the alliance. The quality of the alliance was measured from three perspectives: patients, therapists, and observers. We applied a four step approach to reach the goals of the study. First, we measured the quality of the therapeutic alliance from all three perspectives. Secondly, we examined the connection between patient, therapist, and observer rated therapeutic alliance. Thirdly, we assessed the stability of the therapeutic alliance over time. Finally, we investigated potential predictors of the therapeutic alliance.

Quality of the therapeutic alliance and correlations between rater perspectives

Generally, patients and therapists rated the alliance equally high, while observers rated the alliance consistently lower than both patients and therapists. These findings are in concordance with Fenton, Cecero, Nich, Frakforter, & Carroll (2001), who found that

observers rated the alliance lowest of the three perspectives. Our findings also concur with previous studies (Golden & Robbins, 1990; Horvath & Marx, 1990; Piper et al., 1995; Tichenor & Hill, 1989) which found poor convergence between patient and therapist ratings, suggesting that patients and therapists have different foundations for appraising the quality of the therapeutic relationship. In our study, we found a relationship between patient and therapist ratings early in therapy, but not for late alliance ratings. It might be that the initial encounter between patient and therapist is the point in therapy where they are most similar in their foundations for rating alliance, as patient and therapist yet don't know each other well and the relationship processes have just begun. One of the factors that differentiates the patient's perspective from that of the therapist, is that the patient might come to therapy for the first time not knowing what to expect, with a friendly attitude to most that (s)he experiences. Therapists, on the other hand, have certain expectations both to their own performance, and to that of the patient. Comparing therapists and observers, the many correlations between therapist and observer perspectives in our study might indicate that therapists and observers have the same theoretical basis for evaluating the therapeutic alliance. Still, the lower ratings of observers relative to therapists might indicate that there is a qualitative experiential difference between those who perform therapy, and those who observe therapy. Observers might be less susceptible to situational demands or transference and counter-transference issues that may influence an evaluation of the alliance (Fenton et al., 2001). Observers also have a greater opportunity to notice subtle patient cues which therapists favourably could have used in therapy, and might thereby be stricter in their evaluation of the alliance. The therapist might rate the alliance more favourably than the observer due to self-justification needs (Festinger, 1957), or a positive confirmation bias (Jones

& Sugden, 2001). Self-justification might occur if there is a cognitive dissonance: the therapist notices that he is not acting according to his own standards, but does not see how to change it. He therefore looks for ways to justify his actions, and finds reasons why what happened could also be a good thing. The positive confirmation bias is the tendency to look for what you desire to see, and overlook negative information.

Explanations of the higher patient alliance ratings compared to observer ratings could be that the patients are polite, eager to please (demand characteristics; McLeod & Weisz, 2005), or that patients with internalizing disorders might be low on hostility towards authorities.

The development of therapeutic alliance over time

Our findings show that the alliance is stable from early to late in therapy, as rated by all informants. We found a high correlation between patient, therapist, and observer rated early and late alliance. This confirms that early alliance is predictive of late alliance, and the importance of establishing a good therapeutic alliance early. This is in concordance with previous studies (Bachelor & Salamé, 2000; Greenberg, 1994; Martin et al., 2000). It is possible that therapists and patients quickly decide whether they like each other or not, and that this contributes to the stability of the alliance. Also, alliance might reach a ceiling effect early for therapists and patients in our study, leaving little scope for further improvement. However, although the observers rated the alliance consistently lower than both therapists and patients, this alliance perspective was also stable over time, which contradicts the idea of an early ceiling effect explaining the stability. Another explanation of the stability of all three perspectives could be the anchoring and adjustment heuristics (Tversky & Kahneman, 1974). This

heuristic states that we adjust our judgements to an original anchor. That is, people would not move too far from their initial judgement value on a factor such as alliance.

Due to the fact that measurements of alliance were made only at two points during therapy, our study is not able to say anything about possible alliance fluctuations during the course of therapy. Future studies including more frequent alliance measures might be able to shed light on whether this is the case.

Variables predicting therapeutic alliance

No predictors were similar across all three perspectives. The significant predictors from the patient perspective were mother-rated treatment credibility and child-rated self concept. From the therapist perspective predictors were mother-rated and patient-rated treatment credibility, motivation, and gender. For the observer perspective predictors were motivation and an autonomous parental style.

The correlation analysis showed that individual therapy achieved higher ratings than group therapy, but this tendency vanished as a predictor of alliance in the multiple regressions analysis. One possible explanation is that the impact of format on alliance is explained by other variables, such as mother-rated credibility, motivation, or an autonomous parental style. In our study, these factors were the only ones which remained significant in the regression models where format also appeared. It might also be that other relational processes are present in groups compared to individual therapy, as for example group cohesion (Liber et al., in press). This could explain why alliance is rated higher in individual therapies. Alternatively, format may have lost effect due to our small sample size. It would be of interest to investigate the importance of format in relation to alliance formation in studies with a larger sample.

Mother-rated treatment credibility was a significant predictor of alliance both from the patient and therapist perspective. Parents' faith in treatment is probably an equally, if not more important factor than patient's faith in treatment for children and youth. Parents can contribute considerably to the performance of exposure training at home, and they can make sure that the youngster comes to sessions. Some youngsters might have a lack of faith in the usefulness of therapy (DiGiuseppe et al., 1996; Russell & Shirk, 1998), for which their parents' faith in treatment might compensate.

Further, patient rating of self concept was related to higher quality of late therapeutic alliance. To the best of our knowledge, there is no research to date which informs us about the relationship between self concept and therapeutic alliance. A question is why self concept, which was rated before the start of treatment, did not impact on early therapeutic alliance in addition to late alliance. It could be that the insecurity which follows any new situation overrides the child's positive self concept to an extent that deprives it of its inherent contribution to the therapeutic alliance. Self concept did not significantly contribute to any of the other alliance perspectives. A good self concept might help children to make contact with others, and not being too occupied with worries about other's opinions of them. However, the fact that children's self concept was unrelated to the alliance ratings of therapist and observers, having a good self concept might not be necessary in order for people to be liked. A person with a poor self concept might be just as sympathetic as one with a good self concept.

In addition to credibility rated by mothers, the patient-rated treatment credibility predicted the quality of alliance seen from the therapist perspective. It is possible that patients that have faith in treatment also engage in therapy to a greater extent (Austin & Vancouver, 1996; Meyer et al., 2002), and that therapists notice this as a favourable trait

contributing to their feelings of alliance with the child. It was rather surprising that this factor did not also predict a high alliance from the patients' own perspective, as this trend is found in adult literature (Arnkoff, Glass, & Shapiro, 2002). It is possible that faith in therapy is not related to the concept of alliance in young people's minds, and that there are other factors that determine to what extent they feel well with the therapist. It is not unreasonable to assume that faith in therapy plays different roles for child and adult clients, as children are likely to have different basis for understanding the concept of what therapy is.

Motivation significantly predicted alliance early in therapy for the therapist perspective as well as for the observer perspective. Motivation is probably closely linked to perceived treatment credibility, as both of them hook on to the concept of expectations (e.g., Gibbons et al., 2003). It is probably also linked to the acknowledgement of having a problem that needs to be solved. Such an acknowledgement would give rise to motivation to work with the problem, and thereby for improvement to occur. Estrada & Russell (1999) found moderate correlations between child motivation and therapeutic alliance. Our study confirms the importance of motivation seen from the therapist and observer early perspectives. However, it is interesting that motivation did not predict alliance from the patient's own perspective. We might also wonder why motivation only predicts early alliance rated by therapist and observer. It is possible that motivation is most important early in therapy, and that there are other elements to the relationship that become more important later. Examples could be the ability to co-operate, the experience of being understood and taken seriously, as well as progress and/or symptom relief.

Gender predicted late alliance from the therapist perspective. According to our results, therapists found it easier to maintain a good alliance with girls. This is in concordance with results from the adult literature (Gibbons et al., 2003). It is possible that both girls and boys are perceived as more similar in the beginning of therapy, due to the fact that therapy is equally new to them all. However, CBT treatment have elements which resemble expected classroom behaviour, of which elements (sit still, work with your books) have been shown to fit better for girls than for boys (e.g., An Australian Government Initiative, 2003). It is possible that the ease with which girls do this kind of work, is mirrored in the therapist ratings of alliance. It would, however, be interesting to know whether boys would have been rated higher in alliance by a male therapist.

Motivation and an autonomous parental style predicted therapeutic alliance from the observer perspective. It is possible that youngsters whose parents have brought them up to be autonomous, participate to a greater extent in sessions and that the observers picked this up. If this was the case, one would however expect therapists to experience it similarly. This was not found in our study. A possible explanation could be that observers valued all kinds of participation, while therapists mainly value participation which concord with their agenda. Some of the kids' spontaneous participation could thereby be experienced as a nuisance or waste of time by the therapists.

Symptom severity was significantly correlated to therapist alliance, where therapists tended to rate their alliance to patients with more symptoms higher. This is contrary to the findings from adult literature, where therapists rated their alliance to patients with fewer symptoms higher (Hersoug et al., 2002). It could be that children

who display more symptoms are experienced as more open and trusting in the relationship by the therapist.

Limitations of the study

Our sample of 20 patients was taken out of a total group of 50. These 20 patients were chosen because they had complete data sets and audible videos, contrary to the remaining sample. Conscientiousness in filling in papers might be a consequence of other factors, like socio-economic status, quality of relationships in the family, or motivation for treatment. We have no data that can disconfirm such possibilities and there might be differences between our sample and the total sample which are not known to us.

Our sample of 20 patients is too small to conduct regression analyses with the number of variables included in our study (Pallant, 2005). A sample of this size is at risk of producing chance correlations. We decided to proceed with regression analyses in spite of this, as this is an exploratory pilot study. Our results, although susceptible to flaws, might give indications for further research, as well as for the main study. It is possible that some of the predictors would have appeared as significant with a larger sample. The many predictor variables compared to the small number of participants consequently limit our ability to discover small correlations.

Both the fact that the therapists conducted the treatment for the first time, and that they might have been insecure due to the requirements of the research project, need to be considered when interpreting the results. This might have made the therapists more nervous than normal. Also, they might have become extremely manual adherent due to the research demands. There is a discussion in the field regarding the necessity of

flexibility in manualized treatment. Lack of flexibility might affect alliance negatively (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Eifert, Evans, & McKendrick, 1990; Kendall, Chu, Gifford, Hayes, & Nauta, 1998). Lieber et al (in press) found that a stronger early alliance was related to a better early treatment adherence in individual treatment, but not in group treatment.

Although we checked for outliers and found none, we have not analyzed whether there are systematic differences between the different sites, or between the different therapists. Hence, we don't know if therapist personal style or experience matter for the alliance. However, Poulsen and Sørensen (2008) conducted a study on therapists' treatment integrity in the same pilot study as this one. Treatment integrity comprises therapist adherence to the manual and therapist competence in employing the therapeutic interventions. They found that the therapists had high treatment integrity. Possible therapist effects are beyond the scope of this text, and also our sample of therapists was too small to find reliable effects. However, therapist effects on alliance might be a research question for larger studies.

We watched a few of the group videos up to three times. Although we focused on different children each time and tried to limit repeated ratings of the same video, these videos were not new to us. This might have influenced our concentration during rating, as well as making us preconceived to the content of the videos. We therefore tested the relationship between observer involvement and alliance. We found no systematic differences in how the three observers answered this question, indicating that observer involvement did not abate for the videos that we watched repeatedly.

Therapists and patients rated therapeutic alliance in sessions 3 and 7. Observer ratings of early group sessions were made of sessions 2-4, while observations of

sessions 6-9 were made for late ratings. Ideally, observers should also have consistently watched sessions 3 and 7, in order to make sure that all three perspectives had the same foundation for rating alliance. However, we concluded that it was more important to control for observer preconceptions to the material, than to watch the exact same therapy sessions for early and late ratings. Also, in some cases, audible videotapes were not available for sessions 3 and/or 7.

Parents were also given self-report forms to fill in, but unfortunately this was not done consistently. We therefore lack much information from parents, particularly the fathers. This information would possibly have broadened the perspective of the already obtained information.

One of the symptom measures used in the study, Children's Automatic Thoughts Scale (CATS), only measures one aspect of anxiety, namely negative thoughts. Four aspects are included: anxiety of physical threat, social threat, personal failure and hostility. It is therefore not a scale that captures all aspects of anxiety disorders. Patients would obtain a high score only to the extent that these aspects are part of their disorder. Also, negative thoughts of this sort are not specific to anxiety disorders. However, a high score on the scale does communicate aspects of the symptom level.

Ethics

The project was approved by the Regional Ethical Committee (REK Vest), which by no means indicate that all potential ethical issues are resolved. Patients were not free to choose between individual or group treatment. This could possibly influence motivation, or their willingness to be open and participate in sessions. In addition, children with serious anxiety problems had to wait before they were accepted for one of

the conditions. We don't know to what extent this wait time influenced their anxiety disorder. It is important to note that most children got shorter wait time than usual. In addition, they were included in an evidence-based treatment programme. Also, video recording is a vulnerable situation to put therapists in. It might have limited their freedom to act as usual, in addition to being emotionally challenging. It might also have been uncomfortable for patients to be video recorded, and their openness in therapy might have become restricted.

Strengths of the study

This study included three coder perspectives. This provided the opportunity to compare them, which is unlike several studies which only include one perspective of the alliance. All videos were triple coded, ensuring higher reliability of the observer perspective measure. Unique to this study is the inclusion of several predictor variables, providing an opportunity for discovering a multitude of correlations. Also, due to the small sample, we might expect that the correlations we found would be even stronger in a study with a greater sample. The study is conducted in regular out-patient clinics, which means that the generalizability of the findings to normal patient populations can be expected to be high. The study introduces an evidence based treatment into regular clinics, toward which there is increased pressure by Norwegian Health Authorities. At the same time, the study addresses some of the complexity of using evidence-based treatment by focusing on factors such as motivation, treatment credibility, and therapeutic alliance.

Future recommendations

Further investigations should include a measure of parent-rated therapeutic alliance. Assessing parents' bond to the therapist and their agreement upon the task in therapy may be beneficial, due to parents' roles in bringing children to treatment. It has been shown that youth and parent alliance may play distinctive roles in the processes and outcome of therapy (Hawley & Weisz, 2005).

Secondly, the conceptualization of the therapeutic alliance is complex and dynamic (Safran & Muran, 2000), and one could question if it is possible to grasp this concept by quantitative methods. More qualitative studies, as well as further quantitative studies addressing methodological questions of alliance measurements are needed to increase our understanding of the nature of the alliance. This is also important in order to investigate more closely the role of alliance and its impact on the treatment of anxious children and youth (Chu et al., 2004).

Thirdly, predictors included in this study should be investigated in larger samples, in order to check out if the tendencies we found would gain explanatory value.

Our study indicated that alliance formation might be different based on gender and between individual and group treatment. It is possible that CBT is constructed in a way that fits better for girls. It would therefore be interesting to explore how CBT more adjusted for boys would impact on the alliance. One could also look into whether there would be differences in alliance ratings between female therapists and children of both genders, as well as between male therapists and children of both genders. Further, it would also be useful to conduct studies which particularly investigate alliance in groups versus individual treatment conditions. Another area in need of further research is the impact of treatment manual-use for alliance. One could examine if there would be

alliance differences in therapies that were strictly manual adherent versus flexible in their use of manuals. One such issue might be how the use of personalized examples compared to general examples taken from the manuals would impact on alliance. Our study found a strong influence of mother-rated treatment credibility. It would be interesting to look further into the impact of parents on child ratings of alliance. Further research is required to confirm our preliminary findings.

Tables

Table 1.

Participants' demographic and diagnostic data.

Variable	Individual format (n=6)		Group format (n=14)	
	Boys	Girls	Boys	Girls
Gender	4	2	5	9
Child condition	1	0	2	5
Youth condition	3	2	3	4
Diagnosis				
SAD	1	0	4	4
GAD	3	1	2	6
SOP	3	2	3	4
Comorbidity				
One anxiety diagnosis	1	1	3	5
Two anxiety diagnoses	3	1	0	3
Three anxiety diagnoses	0	0	2	1

Note. SAD = Separation Anxiety; SOP = Social Anxiety Phobia; GAD = Generalized Anxiety Disorder.

Child treatment condition: age $\leq$12, youth treatment condition: age $\geq$12.

Table 2

ICC reliability of 21 TPOCS-A YADS video ratings and 40 TPOCS-A FRIENDS pilot video ratings.

Item "To what extent did the client…	YADS All raters compared to Dr. McLeod	YADS All raters	FRIENDS All raters
B1- indicate that he/she experienced the therapist as understanding and/or supportive?	.80	.80	.86
B2- act in a hostile, critical or defensive manner toward the therapist?	.39	.24	.43
B3- demonstrate positive affect toward the therapist?	.89	.91	.83
B4- share his/her experience with the therapist?	.81	.83	.85
B5- appear uncomfortable when interacting with the therapist?	.64	.70	.73
B6- appear anxious or uncomfortable interacting with each other?	.90	.90	.59
T1- use therapeutic tasks to make changes outside the session?	.78	.76	.83
T2- not comply with therapeutic tasks?	.60	.69	.61
T3- work together equally on therapeutic tasks?"	.86	.83	.63

Note. B = bond item; T = task item; YADS = Youth Anxiety and Depression Study; ICC reliability <.40 = poor, .40-.59 = fair, .60-.74 = good, .75-1.00 = excellent (Ciccetti & Sparrow, 1981).

Table 3.

Independent samples t-test checking for gender differences.

Measures	Boys		Girls		
	Mean	(SD)	Mean	(SD)	P
Patient alliance					
TASC Early	37.8	(7.1)	38.2	(4.2)	NS
TASC Late	39.1	(6.9)	39.8	(4.4)	NS
TASC Average	38.4	(6.8)	39.0	(4.1)	NS
Therapist alliance					
TASC Early	37.3	(6.1)	39.8	(4.7)	NS
TASC Late	38.0	(5.3)	42.2	(4.8)	<0.10
TASC Average	37.7	(4.9)	40.8	(4.5)	NS
Observer alliance					
TPOCS-A Early	28.8	(5.6)	29.2	(5.3)	NS
TPOCS-A Late	28.1	(6.0)	29.2	(1.3)	NS
TPOCS-A Average	28.4	(5.5)	29.2	(4.1)	NS
RBQ					
Control	21.6	(7.8)	20.8	(7.2)	NS
Acceptance	27.6	(5.0)	29.0	(7.4)	NS
Autonomy	39.5	(4.9)	37.5	(4.4)	NS
SC	40.3	(10.0)	33.1	(9.5)	NS
SCAS	24.3	(7.6)	29.1	(13.0)	NS
CATS	19.2	(22.4)	34.9	(20.9)	NS
NML	17.0	(5.2)	17.8	(5.1)	NS
CS-Patient	16.9	(5.5)	17.6	(7.6)	NS
CS-Mother	18.7	(5.4)	20.6	(7.0)	NS

Note. TASC = Therapeutic Alliance Scale for Children; TPOCS-A = Therapy Process Observational Coding System-Alliance*;* RBQ = Rearing Behaviour Questionnaire; SC = Self-Concept scale; SCAS = Spence Children's Anxiety Scale; CATS = Children's Automatic Thoughts Scale; NML = Nijmejgen Motivation List; CS = Credibility Scale; SD = standard deviation.

Table 4.

Independent samples t-test checking for format differences.

Measures	Individual		Group		
	Mean	(SD)	Mean	(SD)	P
Patient alliance					
TASC Early	42.0	(4.1)	36.3	(5.2)	<0.05
TASC Late	41.8	(4.4)	38.5	(5.7)	NS
TASC Average	41.9	(4.2)	37.4	(5.4)	<0.10
Therapist alliance					
TASC Early	42.5	(3.4)	37.4	(5.4)	<0.10
TASC Late	39.6	(5.0)	40.3	(5.7)	NS
TASC Average	41.0	(4.1)	38.6	(5.0)	NS
Observer alliance					
TPOCS-A Early	31.4	(6.6)	28.0	(4.5)	NS
TPOCS-A Late	32.3	(4.8)	27.2	(4.8)	<0.05
TPOCS-A Average	31.8	(5.2)	27.6	(4.0)	<0.10
RBQ					
Control	19.2	(9.1)	22.4	(6.1)	NS
Acceptance	28.5	(4.9)	28.2	(7.0)	NS
Autonomy	40.3	(5.4)	37.4	(4.0)	NS
SC	36.2	(11.0)	36.4	(10.2)	NS
SCAS	26.6	(6.3)	27.1	(12.5)	NS
CATS	32.2	(21.8)	25.3	(23.3)	NS
NML	18.0	(6.3)	17.2	(6.3)	NS
CS-Patient	17.8	(7.9)	17.1	(6.3)	NS
CS-Mother	24.3	(6.1)	18.6	(5.7)	<0.10

Note. TASC = Therapeutic Alliance Scale for Children; TPOCS-A = Therapy Process Observational Coding System-Alliance*;* RBQ = Rearing Behaviour Questionnaire; SC = Self-Concept scale; SCAS = Spence Children's Anxiety Scale; CATS = Children's Automatic Thoughts Scale; NML = Nijmejgen Motivation List, CS = Credibility Scale; SD = standard deviation.

Table 5.

Independent samples t-test checking for age differences.

Measures	Children		Youth		
	Mean	(SD)	Mean	(SD)	P
Patient alliance					
TASC Early	36.4	(6.2)	39.6	(4.4)	NS
TASC Late	38.6	(7.0)	40.4	(3.6)	NS
TASC Average	37.5	(6.5)	40.0	(3.8)	NS
Therapist alliance					
TASC Early	38.0	(6.3)	39.3	(4.4)	NS
TASC Late	39.0	(5.0)	41.2	(5.8)	NS
TASC Average	38.1	(5.2)	40.3	(4.4)	NS
Observer alliance					
TPOCS-A Early	27.8	(4.9)	30.1	(5.7)	NS
TPOCS-A Late	27.9	(4.6)	29.5	(5.6)	NS
TPOCS-A Average	27.9	(4.4)	29.8	(5.0)	NS
RBQ					
Control	19.3	(5.7)	22.3	(8.1)	NS
Acceptance	32.0	(6.7)	26.1	(4.9)	<0.10
Autonomy	39.8	(2.6)	37.7	(5.5)	NS
SC	38.1	(11.7)	34.6	(8.6)	NS
SCAS	24.4	(10.8)	29.0	(11.2)	NS
CATS	23.6	(24.8)	31.0	(20.9)	NS
NML	18.5	(4.0)	16.4	(6.0)	NS
CS-Patient	17.1	(5.4)	17.5	(7.9)	NS
CS-Mother	18.8	(5.5)	21.3	(6.8)	NS

Note. TASC = Therapeutic Alliance Scale for Children; TPOCS-A = Therapy Process Observational Coding System-Alliance*;* RBQ = Rearing Behaviour Questionnaire; SC = Self-Concept scale; SCAS = Spence Children's Anxiety Scale; CATS = Children's Automatic Thoughts Scale; NML = Nijmejgen Motivation List; CS = Credibility Scale; SD = standard deviation.

Table 6.

Means, standard deviations, and total alliance scores of the therapeutic alliance.

Measures	N	Mean	SD	Total Alliance Score %
Patients				
TASC Early	20	38.0	5.5	79.2%
TASC Late	20	39.5	5.5	82.3%
TASC Average	20	38.8	5.4	80.8%
Therapists				
TASC Early	18	38.6	5.4	80.4%
TASC Late	18	40.1	5.4	83.5%
TASC Average	17	39.1	4.8	81.5%
Observers				
TPOSC-A Early	20	29.0	5.3	64.4%
TPOCS-A Late	20	28.7	5.0	63.8%
TPOCS-A Average	20	28.8	4.7	64.0%

Note. TASC = Therapeutic Alliance Scale for Children; TPOCS-A = Therapy Process

Observational Coding System-Alliance; SD = standard deviation.

Table 7.

Correlations between the therapeutic alliance rated by patients, therapists, and observer.

	Patient alliance			Therapist alliance			Observer alliance		
Measures	TASC Early	TASC Late	TASC Average	TASC Early	TASC Late	TASC Average	TPOCS-A Early	TPOCS-A Late	TPOCS-A Average
Patients									
TASC-Early	-								
TASC Late	.903**	-							
TASC Average	.976**	.975**	-						
Therapists									
TASC Early	.521*	.418	.481*	-					
TASC Late	.178	.219	.203	.583*	-				
TASC Average	.458	.407	.443	.886**	.894**	-			
Observers									
TPOCS-A Early	.024	-.136	-.057	.538*	.525*	.611**	-		
TPOCS-A Late	.037	-.106	-.035	.420	.542*	.578*	.627**	-	
TPOCS-A Average	.033	-.135	-.052	.532*	.583*	.656**	.908**	.896**	-

Note. TASC = Therapeutic Alliance Scale for Children; TPOCS-A = Therapy Process Observational Coding System-Alliance. **p<.01. *p<.05.

Table 8.

Correlations between predictor variables and the therapeutic alliance rated by patients, therapists, and observers.

	Patient alliance			Therapist alliance			Observer alliance		
	TASC Early	TASC Late	TASC Average	TASC Early	TASC Late	TASC Average	TPOCS Early	TPOCS Late	TPOCS Average
1) Background Predictors									
Gender (N=20)	.037	.066	.053	.232	.406*	.335	.036	.115	.083
Age condition (N=20)	.298	.169	.240	.118	.213	.235	.222	.170	.218
Treatment format (N=20)	.488**	.286	.397*	.401*	-.061	.219	.304	.478**	.431*
2) Parental style RBQ (N=16)									
Control	.087	.374	.238	-.070	.397	.240	-.368	-.297	-.388
Acceptance	-.155	-.312	-.241	.248	-.116	.002	.299	.337	.372
Autonomy	.030	-.170	-.072	.221	-.121	.035	.454	.536**	.579**
3) Self concept									
SC (N=20)	.318	.446**	.392*	-.062	.046	.029	.009	-.182	-.093
4) Symptom Severity									
SCAS (N=18)	-.134	-.237	-.190	.491*	.299	.392	.162	.095	.144
CATS (N=19)	-.089	-.211	-.154	.524**	.381	.492*	.305	.323	.345
Co-morbidity	-.244	-.342	-.300	-.137	.239	.039	.335	.102	.246
5) Motivation and Credibility									
NML (N=20)	.076	-.132	-.029	.636***	.229	.470*	.396*	.249	.360
CS-Patient (N=20)	.255	.089	.176	.388	.407*	.472*	.334	.318	.362
CS-Mother (N=18)	.583**	.530**	.568**	.540**	.248	.454*	.137	.109	.143

Note. TASC = Therapeutic Alliance Scale for Children; TPOCS-A = Therapy Process Observational Coding System-Alliance; RBQ = Rearing Behaviour Questionnaire; SC = Self-Concept scale; SCAS = Spence Children's Anxiety Scale; CATS = Children's Automatic Thoughts Scale; NML = Nijmejgen Motivation List, CS = Credibility Scale. *p<0.10, **p<0.05, ***p<0.01; 2 - tailed test.

Table 9.

Multiple regressions with patient-rated alliance as the dependent variables.

	Adjusted R^2	Beta	P
Alliance Early	0.34		<0.05
Format		0.31	NS
CS-mothers		0.46	<0.05
Alliance Late	0.28		<0.10
SC		0.37	<0.10
CS-mothers		0.42	<0.10
Format		0.11	NS
Alliance Average	0.34		<0.05
Format		0.24	NS
SC		0.32	NS
CS-mothers		0.42	<0.10

Note: Format= Individual or group therapy; CS= Credibility Scale; SC= Self-Concept scale.

Table 10.

Multiple regressions with therapist-rated alliance as the dependent variables.

	Adjusted R^2	Beta	P
Alliance Early	0.85		<0.000
Format		0.07	NS
SCAS		0.01	NS
CATS		0.22	NS
NML		0.64	<0.000
CS-mothers		0.63	<0.000
Alliance Late	0.22		<0.10
Gender		0.38	<0.10
CS-patients		0.39	<0.10
Alliance Average	0.20		NS
CATS		0.36	NS
NML		0.26	NS
CS-patients		0.58	NS
CS-mothers		0.54	NS
Format		-0.24	NS

Note: Format= Individual or group therapy; SCAS = Spence Children's Anxiety Scale; CATS = Children's Automatic Thoughts Scale; NML = Nijmejgen Motivation List, CS = Credibility Scale.

Table 11.

Multiple regressions with observer-rated alliance as the dependent variables.

	Adjusted R^2	Beta	P
Alliance Early	0.11		<0.10
NML		0.40	<0.10
Alliance Late	0.40		<0.05
Format		0.35	NS
RBQ Autonomy		0.44	<0.10
Alliance Average	0.41		<0.05
Format		0.29	NS
RBQ Autonomy		0.50	<0.05

Note: NML= Nijmejgen Motivational List; Format= Individual or group therapy; RBQ = Rearing Behaviour Questionnaire; CS = Credibility Scale.

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Appendix A

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Einar Heiervang
Barne- og ungdomspsykiatrisk avdeling
Haukeland universitetssykehus
5021 BERGEN

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Harald Hårfagres gate 29
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Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Vår dato: 12.03.2007 Vår ref: 16411/LT Deres dato: Deres ref:

TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 19.02.2007. Meldingen gjelder prosjektet:

16411	*Kartlegging og behandling – angst hos barn og voksne: Pilotstudie i barnedelen*
Behandlingsansvarlig	*Helse Bergen HF, ved institusjonens øverste leder*
Daglig ansvarlig	*Einar Heiervang*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/endringsskjema. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/database/

Personvernombudet vil ved prosjektets avslutning, 31.12.2010 rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Bjørn Henrichsen Lis Tenold

Kontaktperson: Lis Tenold tlf: 55 58 33 77

Vedlegg: Prosjektvurdering

Appendix B

UNIVERSITETET I BERGEN
Regional komité for medisinsk og helsefaglig forskningsetikk, Vest-Norge (REK Vest)

Overlege Einar Heiervang
Klinikk psykisk helsevern for barn og unge
Haukeland Universitetssykehus
5021 Bergen

Deres ref	Vår ref	Dato
	2007/12776-ANØL	03.10.2007

Ad. prosjekt: Kognitiv atferdsterapi mot angst hos barn og unge (204.07).

Det vises til din søknad om godkjenning av forskningsprosjekt, datert 13.09.07.

Komiteen behandlet søknaden i møte den 27.09.07.

De regionale komiteene for medisinsk og helsefaglig forskningsetikk foretar sin forskningsetiske vurdering med hjemmel i Forskningsetikklovens § 4. Saksbehandlingen følger Forvaltningsloven.

Komiteen mener dette er en uproblematisk studie.
En har ingen merknader til forelagt prosjektbeskrivelse.

Vedtak:
Studien er godkjent og kan gjennomføres i samsvar med forelagt søknad.

Komiteen ber om å få tilsendt sluttrapport evt. trykt publikasjon for studien når dette foreligger.

Vennlig hilsen

Jon Lekven
leder

Anne Berit Ølmheim
førstekonsulent

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Saksbehandler
Anne Berit Ølmheim
55 97 84 99

Appendix C

Forespørsel om deltakelse i forskningsprosjekt

Som ledd i planleggingen av et forskningsprosjekt på behandling av angst hos barn og ungdom, skal det gjennomføres en pilotfase for å få erfaring med metodene for utredning og behandling før hovedfasen gjennomføres. Prosjektets tittel er ”Kartlegging og behandling – angst hos barn og voksne”. Denne forespørselen gjelder barnedelen, hvor effekten av gruppeterapi skal sammenlignes med individualterapi. Foreldres/foresattes deltakelse er viktige i begge behandlingsformene.

Behandlingen kalles kognitiv atferdsterapi, og går ut på å lære å kjenne kroppens reaksjoner ved angst, avslapningsøvelser, erstatte negative med positive tanker, lære å forberede seg på situasjoner barna er engstelige for, og å trene seg på slike situasjoner. Oppgaver man skal trene på mellom hver time er en viktig del av behandlingen, og dette øver barna på sammen med sine foreldre. Behandlingsprogrammet som skal prøves ut i barnedelen av prosjektet kalles FRIENDS, og er utviklet av professor Paula Barrett i Australia. Det går over 10 ukentlige samlinger, hver på 75-90 minutter. Foreldre deltar på slutten av hver time, og det er også to samlinger underveis bare for foreldre. Etter de 10 ukene er det oppfølgingstimer 1 og 3 måneder senere.

Det er bare barn og ungdommer som er henvist til de deltakende BUP poliklinikker som kan delta i prosjektet. Det er bestemte krav til type og grad av angstproblemer for å kunne delta, og ikke alle med angst vil egne seg for denne behandlingen. Man må være mellom 8 og 15 år for å delta. Det er egne grupper for barn (8-12 år) og for ungdom (12-15 år). Behandlerne ved poliklinikken vurderer hvilke barn og ungdommer som er aktuelle for deltakelse i prosjektet. Hvis foresatte samtykker til at barna/ungdommen kan delta, vil det bli gjort intervjuer for å finne ut om de passer i studien. Barna/ungdommene som deltar og deres foresatte må være villige til å besvare spørreskjema før, under og etter behandlingen, og bli intervjuet etter avsluttet behandling. Dette er viktig for at vi skal kunne vurdere om virkningen av behandlingen. Det er nødvendig å gjøre videoopptak av behandlingene underveis. Det vil bli loddtrekning blant deltakerne om hvem som blir tilbudt gruppeterapi eller individualterapi.

Behandlingen som skal prøves ut har vist gode resultater i studier i utlandet. Vi håper at den også skal kunne hjelpe barn og ungdom med angstproblemer i Norge. Vi vil også undersøke hvordan

behandlingen virker og hvem som har mest nytte av den. Det er ingen kjent risiko med å delta i behandlingen, som vil bli gitt av erfarne behandlere som har fått opplæring og veiledning i metoden.

Hvis noen ønsker å trekke seg fra deltakelse underveis vil de bli tilbudt annen behandling ved poliklinikken. Er man i gang med annen behandling for angstsymptomer, kan det være denne må avbrytes mens man deltar i FRIENDS. Hvis man ikke er blitt bra etter å ha gjennomgått FRIENDS, vil man få tilbud om annen behandling ved poliklinikken.

Foresatte har rett til å kreve innsyn og retting og sletting av opplysninger. Foresatte har også rett til tilbakemelding om eller tilgang til resultater for sitt barn etter at prosjektet er avsluttet. Videoopptak vil bli slettet senest ved avslutning av prosjektet 31.12.2010, hvis ikke tillatelse til videre oppbevaring er innhentet. Når barnet fyller 16 år skal han/hun selv ta stilling til videre deltakelse og oppbevaring av data. Etter avslutning av prosjektet vil data bli anonymisert og videoopptak slettet, hvis ikke ny tillatelse til oppfølgingsundersøkelse er innhentet. Opplysninger og materiale som allerede har allerede har inngått i vitenskapelige analyser kan ikke trekkes tilbake.

Deltakelse i prosjektet er frivillig. Samtykke kan trekkes tilbake på et hvilket som helst tidspunkt uten at man må oppgi grunn eller at det får konsekvenser for tilbudet man senere får fra poliklinikken. Informasjon om deltakerne som inngår i analyser og lagres andre steder enn på poliklinikken vil kun bli identifisert ved bruk av tallkode. Liste med kobling mellom navn og tallkode oppbevares nedlåst på poliklinikken. Alle opplysninger vil bli behandlet konfidensielt. Forskerne har taushetsplikt for opplysninger innhentet om enkeltpersoner i prosjektet.

Prosjektet ledes av overlege dr.med. Einar Heiervang ved Haukeland Universitetssykehus, Bergen, som er ansvarlig for behandlingen av data i prosjektet. Han kan kontaktes direkte eller via behandlerne ved de poliklinikker som deltar i prosjektet. Prosjektet finansieres av Helse Vest, med støtte av Universitetet i Bergen og de deltakende helseforetak. Prosjektledere og medarbeidere har ingen økonomiske interesser i prosjektet. De som deltar i prosjektet er dekket av pasientskadeerstatningsordningen.

Pilotfasen av prosjektet som er omtalt ovenfor er tilrådd av Regional komité for medisinsk forskningsetikk, Helseregion Vest, og av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Jeg samtykker til selv å delta / at mitt barn deltar (stryk det som ikke passer) i pilotfasen av forskningsprosjektet slik det er beskrevet ovenfor.

Dato:…….. Barnets/ungdommens navn:…….

Underskrift……..

Mor/far/barn/ungdom/andre (oppgi evt hvem:……..)

Appendix D

Forespørsel om tillatelse til å kode pilotvideoer i Friends-prosjektet

Under den delen av Friends-prosjektet som handler om prosess- og relasjonsvariabler ønsker vi din tillatelse til å kode et utvalg av pilotvideoene fra timene der du var hovedbehandler. Dine videoer var blant de videoene fra pilotprosjektet hvor vi har fullstendige nok spørreskjemadata til å kunne bruke materialet som grunnlag for en publikasjon. Vi ønsker å bruke videomateriale fra din pilot-terapi til koding av terapeutisk allianse til bruk i en artikkel som vil inngå i Fjermestads doktoravhandling. Kodingsinstrumentet som vil bli brukt er "The Therapeutic Process Observation Coding System-Alliance Scale" (TPOCS-A), som er utviklet av Dr Bryce McLeod ved Virginia Commonwealth University. Skjemaet består av 9 ledd som kodes av en uavhengig observatør. Leddene omhandler den følelsesmessige relasjonen mellom klient og behandler i timen, og graden av samarbeid mellom klient og behandler om terapeutiske oppgaver. Målet med videokodingen er å forsøke å besvare problemstillinger knyttet til hvorvidt der er sammenheng mellom egenrapportert opplevelse av terapeutisk allianse (fra spørreskjemadata) og terapeutisk allianse kodet av observatør, samt hvordan alliansen utvikler seg under terapiforløpet. Videoene vil kodes av Fjermestad og 2 studenter på 9.semester ved profesjonsstudiet i psykologi, som alle er opplært av Dr. McLeod i TPOCS-A. Ingen personidentifiserende opplysninger vil bli rapportert fra kodingen, verken om terapeuter eller Friends-deltakere. Dersom du har spørsmål om videokodingen, ta gjerne kontakt med Fjermestad på 94201947.

Dr. Einar Heiervang Fjermestad
Prosjektleder

Krister W.
Stipendiat

Appendix E

Samtykkeerklæring

Jeg samtykker til at videoer hvor jeg hovedbehandler fra pilotprosjektet ”Friends” kan kodes av doktorgradsstipendiat Krister W. Fjermestad og 2 profesjonsstudenter i psykologi på 9. semester. Videoen skal kodes med TPOCS-A, et rating-instrument for terapeutisk allianse.

Sted: _____

Dato: _____

Navn: _____

Underskrift: _____

Appendix F

AVTALE OM OPPTAK OG LAGRING AV VIDEO AV INTERVJU OG BEHANDLINGSTIMER FOR PILOTFASEN TIL BARNEDELEN AV PROSJEKTET
"KARTLEGGING OG BEHANDLING – ANGST HOS BARN OG VOKSNE"

Som deltaker/på vegne av mitt barn som deltar (stryk det som ikke passer) i prosjektet ovenfor samtykker jeg til at innspilt materiale (videobånd) oppbevares av prosjektleder til prosjektets avslutning 31.12.2010. Videoopptakene skal brukes til forskning, veiledning og undervisning innenfor prosjektet, og skal oppbevares slik at ingen uvedkommende kan få adgang til dem. Bare de personer som prosjektleder har godkjent og som har skrevet under taushetserklæring skal ha tilgang på materialet. Publiserte resultater skal være på gruppenivå og det skal ikke være mulig å gjenkjenne enkeltpersoner. Jeg er informert om at jeg kan når som helst kan trekke tilbake dette samtykket og avbryte deltakelsen i prosjektet uten nærmere begrunnelse, og at jeg da kan få data som ikke allerede er analysert om meg/mitt barn slettet om jeg ønsker.

Dato_____ Barnets/ungdommens navn_____

Underskrift_____

Mor/far/barn/ungdom//andre (oppgi evt hvem:.....)

BUP..... DATO..... ID NR.....

RBQ – Barn/Ungdom – Mor
T1 – T2 – T3

Foreldre forsøker på forskjellige måter å oppdra sine barn. Vi ønsker at du beskriver noen av de tingene din mor gjør når hun forsøker å oppdra deg. Vær snill å les hver setning og lag en sirkel rundt det svaret som best beskriver hvordan din mor er i forhold til deg.

(1) Ikke riktig i det hele tatt
(2) Litt riktig
(3) Ganske riktig
(4) Svært riktig

Min mor....

1)....oppmuntrer meg til å gjøre mine egne valg	1	2	3	4
2)....hjelper meg å lære å klare meg selv	1	2	3	4
3)....føler hun må sloss for meg når jeg har en konflikt med en lærer eller en venn	1	2	3	4
4)....overbeskytter meg	1	2	3	4
5)....oppmuntrer meg til å gjøre ting selv	1	2	3	4
6)....oppmuntrer meg til å gjøre ting på min egen måte	1	2	3	4
7)....lar meg ikke få gjøre ting som andre barn på min alder får lov til	1	2	3	4
8)....misliker noen ganger ting jeg gjør, men gir meg aldri følelsen av at hun misliker meg som person	1	2	3	4
9)....liker å være sammen med meg	1	2	3	4
10)....er en jeg synes det er vanskelig å gjøre fornøyd	1	2	3	4

BUP..... DATO..... ID NR.....

(1) Ikke riktig i det hele tatt
(2) Litt riktig
(3) Ganske riktig
(4) Svært riktig

Min mor....

11)....forteller meg om alt hun har gjort for meg	1	2	3	4
12)....forteller meg hele tiden hvordan jeg burde oppføre meg	1	2	3	4
13)....sier at hvis jeg virkelig var glad i henne, ville jeg ikke gjøre ting som gjorde henne bekymret	1	2	3	4
14)....ville ha likt om hun hele tiden kunne fortelle meg hva jeg skulle gjøre	1	2	3	4
15)....støtter meg når jeg ønsker å gjøre nye og spennende ting	1	2	3	4
16)....bekymrer seg for mye for om jeg kan bli skadet eller bli syk	1	2	3	4
17)....er ofte frekk/uhøflig mot meg	1	2	3	4
18)....liker ikke å ha meg hjemme	1	2	3	4
19)....vil gjerne gjøre ting for meg som jeg kan gjøre selv	1	2	3	4
20)....lar meg ta bestemme over mine egne penger	1	2	3	4
21)....prøver alltid å forandre meg	1	2	3	4
22)....ønsker å kontrollere alt jeg gjør	1	2	3	4
23)....følger regler bare nå det passer henne	1	2	3	4
24)....er mindre vennlig mot meg, hvis jeg ikke er enig med henne	1	2	3	4

BUP..... DATO..... ID NR.....

(1) Ikke riktig i det hele tatt
(2) Litt riktig
(3) Ganske riktig
(4) Svært riktig

Min mor....

25)....vil unngå å se på meg når jeg har skuffet henne	1	2	3	4
26)....ønsker ikke at jeg skal bli stor	1	2	3	4
27)....prøver å få meg til å bli glad når jeg er ulykkelig	1	2	3	4
28)....oppmuntrer meg til å si min mening	1	2	3	4
29)....gir meg følelsen av at jeg er en byrde/belastning for henne	1	2	3	4
30)....gir meg følelsen av at hun liker meg slik jeg er; hun ønsker ikke å forandre meg	1	2	3	4
31)....gjør sjelden ting sammen med meg	1	2	3	4
32)....hvis jeg har såret henne, stopper hun å snakke til meg helt til jeg har gjort henne fornøyd igjen	1	2	3	4
33)....jeg kan stole på min mor når jeg virkelig trenger henne	1	2	3	4

Appendix H

BUP..... DATO..... ID NR.....

SCS Barn/Ungdom

T1 – T2 – T3

Dette er en liste over tanker og følelser som mennesker opplever.

Les hver setning nøye, og kryss av det svaret som best beskriver det du føler.

	Aldri	Av og til	Ofte	Alltid
1. Jeg arbeider hardt	☐	☐	☐	☐
2. Jeg føler meg sterk	☐	☐	☐	☐
3. Jeg er fornøyd med meg selv	☐	☐	☐	☐
4. Andre vil være sammen med meg	☐	☐	☐	☐
5. Jeg er like bra som andre barn	☐	☐	☐	☐
6. Jeg føler meg normal	☐	☐	☐	☐
7. Jeg er et godt menneske	☐	☐	☐	☐
8. Jeg gjør ting på en god måte	☐	☐	☐	☐
9. Jeg kan gjøre ting uten hjelp	☐	☐	☐	☐
10. Jeg føler meg smart	☐	☐	☐	☐
11. Folk synes jeg er flink	☐	☐	☐	☐
12. Jeg er snill mot andre	☐	☐	☐	☐
13. Jeg er en hyggelig person	☐	☐	☐	☐
14. Jeg er god til å fortelle vitser	☐	☐	☐	☐
15. Jeg har god hukommelse	☐	☐	☐	☐
16. Jeg forteller sannheten	☐	☐	☐	☐
17. Jeg er stolt over det jeg gjør	☐	☐	☐	☐
18. Jeg er god til å tenke	☐	☐	☐	☐
19. Jeg er fornøyd med kroppen min	☐	☐	☐	☐
20. Jeg er fornøyd med meg selv	☐	☐	☐	☐

Appendix I

SPENCE ANGSTSKALA FOR BARN (SCAS-C)

Navnet ditt: Dato:

LAG EN SIRKEL RUNDT ORDET SOM VISER HVOR OFTE HVER AV DISSE TINGENE SKJER MED DEG. DET ER INGEN RIKTIGE ELLER GALE SVAR.

1. Jeg bekymrer meg for ting.....	Aldri	Av og til	Ofte	Alltid
2. Jeg er mørkredd.....	Aldri	Av og til	Ofte	Alltid
3. Jeg får en rar følelse i magen når jeg har et problem.....	Aldri	Av og til	Ofte	Alltid
4. Jeg føler meg redd.....	Aldri	Av og til	Ofte	Alltid
5. Jeg ville vært redd for å være alene hjemme.....	Aldri	Av og til	Ofte	Alltid
6. Jeg føler meg redd når jeg skal ha en prøve.....	Aldri	Av og til	Ofte	Alltid
7. Jeg blir redd hvis jeg må bruke offentlige toaletter eller bad.....	Aldri	Av og til	Ofte	Alltid
8. Jeg bekymrer meg for å være borte fra foreldrene mine..	Aldri	Av og til	Ofte	Alltid
9. Jeg er redd for å dumme meg ut foran andre.....	Aldri	Av og til	Ofte	Alltid
10. Jeg bekymrer meg for å gjøre det dårlig på skolen.....	Aldri	Av og til	Ofte	Alltid
11. Jeg er populær blant andre barn på min egen alder.....	Aldri	Av og til	Ofte	Alltid
12. Jeg bekymrer meg for at noe forferdelig skal skje med noen i familien min.....	Aldri	Av og til	Ofte	Alltid
13. Jeg får plutselig en følelse av at jeg ikke får puste selv om det ikke er noe grunn for det.....	Aldri	Av og til	Ofte	Alltid
14. Jeg må sjekke om og om igjen at jeg har gjort ting riktig (som at lyset er slukket og døren er låst).....	Aldri	Av og til	Ofte	Alltid
15. Jeg føler meg redd hvis jeg må sove alene.....	Aldri	Av og til	Ofte	Alltid
16. Jeg har problemer med å gå på skolen om morgenen fordi jeg er nervøs eller redd.....	Aldri	Av og til	Ofte	Alltid
17. Jeg er god i sport.....	Aldri	Av og til	Ofte	Alltid

18. Jeg er redd for hunder.....	Aldri	Av og til	Ofte	Alltid
19. Jeg klarer visst ikke å få vonde eller dumme tanker ut av hodet mitt.....	Aldri	Av og til	Ofte	Alltid
20. Når jeg har et problem slår hjertet mitt veldig fort.....	Aldri	Av og til	Ofte	Alltid
21. Jeg begynner plutselig å skjelve eller riste når det ikke er noen grunn til det.....	Aldri	Av og til	Ofte	Alltid
22. Jeg bekymrer meg for at noe vondt skal skje med meg..	Aldri	Av og til	Ofte	Alltid
23. Jeg er redd for å gå til lege eller tannlege.....	Aldri	Av og til	Ofte	Alltid
24. Når jeg har et problem føler jeg meg skjelven.....	Aldri	Av og til	Ofte	Alltid
25. Jeg er redd for å være på høye steder eller i heiser.....	Aldri	Av og til	Ofte	Alltid
26. Jeg er et godt menneske.....	Aldri	Av og til	Ofte	Alltid
27. Jeg må tenke på spesielle ting (for eksempel tall eller ord) for å hindre at det skjer vonde ting.....	Aldri	Av og til	Ofte	Alltid
28. Jeg føler meg redd hvis jeg må reise med bil, buss eller tog.....	Aldri	Av og til	Ofte	Alltid
29. Jeg bekymrer meg for hva andre tenker om meg.....	Aldri	Av og til	Ofte	Alltid
30. Jeg er redd for å være på steder med mange mennesker (som handlesentre, kino, buss, lekeplass med mange barn).....	Aldri	Av og til	Ofte	Alltid
31. Jeg føler meg glad.....	Aldri	Av og til	Ofte	Alltid
32. Jeg kan plutselig bli veldig redd uten noen spesiell grunn.....	Aldri	Av og til	Ofte	Alltid
33. Jeg er redd for insekter eller edderkopper.....	Aldri	Av og til	Ofte	Alltid
34. Jeg føler meg plutselig svimmel eller at jeg vil besvime uten at det er noen grunn for det.....	Aldri	Av og til	Ofte	Alltid
35. Jeg føler meg redd hvis jeg må snakke foran klassen min.....	Aldri	Av og til	Ofte	Alltid
36. Hjertet mitt begynner plutselig å slå for fort uten grunn.	Aldri	Av og til	Ofte	Alltid
37. Jeg bekymrer meg for at jeg plutselig skal føle meg redd, uten at det er noe å være redd for.....	Aldri	Av og til	Ofte	Alltid

38. Jeg liker meg selv.....	Aldri	Av og til	Ofte	Alltid
39. Jeg er redd for å være på små lukkede steder, som i tunneler eller små rom.....	Aldri	Av og til	Ofte	Alltid
40. Jeg må gjøre enkelte ting om og om igjen (som å vaske hendene mine, gjøre reint eller legge ting i en bestemt rekkefølge).....	Aldri	Av og til	Ofte	Alltid
41. Jeg blir plaget av vonde eller dumme tanker eller bilder i hodet mitt.....	Aldri	Av og til	Ofte	Alltid
42. Jeg må gjøre visse ting på nøyaktig riktig måte for å hindre at det skal skje vonde ting.....	Aldri	Av og til	Ofte	Alltid
43. Jeg er stolt av skolearbeidet mitt.....	Aldri	Av og til	Ofte	Alltid
44. Jeg ville blitt redd hvis jeg måtte overnatte hjemmefra...	Aldri	Av og til	Ofte	Alltid
45. Er det noe annet du er virkelig redd for? Vær snill å skriv ned hva dette er_____	JA	NEI		
_____				
_____				
Hvor ofte er du redd for disse tingene?.....	Aldri	Av og til	Ofte	Alltid

Oversatt til norsk av Bente Storm Mowatt Haugland, Kristin Oeding, Krister Fjermestad og Einar Heiervang, Universitetet i Bergen. Tilbakeoversatt av Melanie Young, 2007.

Appendix J

ID NR..... DATO..... BUP.....

CATS2 – T1
Barn/Ungdom

Nedenfor finner du noen tanker som barn og ungdom har fortalt at dukker opp i hodene deres. Les gjennom hver setning nøye og beskriv om, og hvor ofte, hver av tankene har dukket opp i hodet ditt ***den siste uken***. Sett en sirkel rundt hvert av svarene dine.

0 = Ikke i det hele tatt
1 = Av og til
2 = Ganske ofte
3 = Ofte
4 = Hele tiden

1. Barn vil synes at jeg er dum	0	1	2	3	4
2. Jeg kommer til å bli utsatt for en ulykke	0	1	2	3	4
3. Jeg er redd for at noen skal erte meg	0	1	2	3	4
4. Jeg holder på å bli gal	0	1	2	3	4
5. Barn kommer til å le av meg	0	1	2	3	4
6. Jeg kommer til å dø	0	1	2	3	4
7. Mamma eller pappa kommer til å bli skadet	0	1	2	3	4
8. Jeg kommer til å se dum ut	0	1	2	3	4
9. Jeg er redd for å miste kontrollen	0	1	2	3	4
10. Folk tenker vonde ting om meg	0	1	2	3	4
11. Jeg kommer til å bli skadet	0	1	2	3	4
12. Jeg er redd for hva andre barn vil tenke om meg	0	1	2	3	4
13. Noe forferdelig kommer til å skje	0	1	2	3	4
14. Jeg ser ut som en idiot	0	1	2	3	4
15. Andre barn gjør narr av meg	0	1	2	3	4
16. Alle stirrer på meg	0	1	2	3	4
17. Jeg er redd for at jeg vil dumme meg ut	0	1	2	3	4
18. Jeg er redd for at noen kan komme til å dø	0	1	2	3	4
19. Det er noe veldig galt med meg	0	1	2	3	4
20. Noe vil skje med noen jeg bryr meg om	0	1	2	3	4

Appendix K

NML – Barn/Ungdom
T1

Les gjennom hver påstand nedenfor, og avgjør hvor godt det stemmer med dine tanker om FRIENDS programmet. Svar ved å krysse av i ruten som best beskriver hva du tenker. Din FRIENDS leder vil ikke få vite hva du har svart, hverken under FRIENDS programmet eller når det er ferdig.

	Stemmer helt	**Stemmer delvis**	**Stemmer ikke**
1. Mine problemer gjør meg ulykkelig			
2. Jeg er villig til hva som helst for å bli kvitt problemene mine			
3. Jeg tror FRIENDS programmet er den riktige hjelpen for meg			
4. Jeg trenger hjelp med det samme for å løse mine problemer			
5. Jeg er sikker på at jeg kommer til å øve hjemme på det jeg lærer i FRIENDS programmet			
6. Jeg tror jeg kommer til å lære mer i FRIENDS programmet hvis jeg er med og bestemmer og gjør ting			
7. Jeg er villig til å ta fri fra skolen eller en fritidsaktivitet for å være med på FRIENDS programmet			
8. Jeg skammer meg over problemene mine			
9. Jeg vil gjøre alt jeg kan for å komme tidsnok til 10. FRIENDS programmet			
11. Jeg er sikker på at det vil gå bra i FRIENDS programmet			
12. Jeg gjorde rett når jeg bestemte meg for å væ 13. på FRIENDS programmet			
14. Mine problemer gjør at jeg lager vanskeligheter for andre			
15. Mine problemer vil forsvinne når jeg er med på FRIENDS			
16. Mine problemer plager meg			
17. Jeg får mye støtte fra min familie og andre personer			

Appendix L

CS Barn/Ungdom
T1

Spørsmålene nedenfor stilles til alle som deltar i Friends. Hensikten er ikke å vurdere Friends lederen, men å få vite hva du synes om Friends programmet du nettopp har fått beskrevet.

1. Hvor **logisk** synes du FRIENDS programmet virker?

0	1	2	3	4	5	6	7	8
Ikke logisk				Ganske logisk				Svært logisk

2. Hvor sikker er du på at FRIENDS programmet vil være **vellykket** for din angst?

0	1	2	3	4	5	6	7	8
Ikke sikker				Ganske sikker				Svært sikker

3. Hvor sikker er du på at du ville **anbefale** FRIENDS programmet til en venn som har samme angst som deg?

0	1	2	3	4	5	6	7	8
Ikke sikker				Ganske sikker				Svært sikker

4. Hvor vellykket tror du FRIENDS programmet vil være for **en annen form for angst**?

0	1	2	3	4	5	6	7	8
Ikke vellykket				Ganske vellykket				Svært vellykket

CS Foreldre

T1

Spørsmålene nedenfor stilles til alle som deltar i FRIENDS programmet. Hensikten er ikke å vurdere FRIENDS lederen, men å få vite hva du synes om FRIENDS programmet du nettopp har fått beskrevet.

5. Hvor **logisk** synes du FRIENDS programmet virker?

0	1	2	3	4	5	6	7	8
Ikke logisk				Ganske logisk				Svært logisk

6. Hvor sikker er du på at FRIENDS programmet vil være **vellykket** for ditt barns angst?

0	1	2	3	4	5	6	7	8
Ikke sikker				Ganske sikker				Svært sikker

7. Hvor sikker er du på at du ville **anbefale** FRIENDS programmet til en venn som har barn med samme angst som ditt barn?

0	1	2	3	4	5	6	7	8
Ikke sikker				Ganske sikker				Svært sikker

8. Hvor vellykket tror du FRIENDS programmet vil være for **en annen form for angst?**

0	1	2	3	4	5	6	7	8
Ikke vellykket				Ganske vellykket				Svært vellykket

Appendix M

TASC–r
Barn/Ungdom
Time 3 og 7

Her er noen setninger om møtet du hadde med FRIENDS lederen din i dag. Etter å ha lest setningen, ber vi deg sette ring rundt svaret som best beskriver din opplevelse av timen i dag. Husk, FRIENDS lederen din vil ikke få se svarene dine. Det er ingen rette eller gale svar, bare hvordan du opplevde det.

1. **Jeg likte å tilbringe tid sammen med min Friends leder.**

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

2. **Jeg synes det var vanskelig å samarbeide med min Friends leder om å løse problemer i livet mitt.**

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

3. **Jeg følte at Friends lederen var på min side og forsøkte å hjelpe meg.**

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

4. **Jeg jobbet sammen med Friends lederen min med å lære nye måter å takle følelsene mine på.**

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

5. **Jeg ville at timen skulle bli fort ferdig.**

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

6. **Jeg gledet meg til å møte Friends lederen min.**

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

7. Jeg følte at Friends lederen brukte for mye tid på å jobbe med mine problemer.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

8. Jeg ville heller gjort andre ting enn å møte Friends lederen min.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

9. Jeg brukte tiden med Friends lederen min til å forandre måten jeg oppfører meg på.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

10. Jeg likte Friends lederen min.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

11. Jeg ville helst ikke jobbet med problemene mine sammen med min Friends leder.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

12. Jeg syntes Friends lederen min og jeg samarbeidet godt om å løse problemene mine.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

TASC–r
Terapeut om Barnet/Ungdommen
Time 3 og 7

Hvordan vurderer du barnet i dagens Friends time på skalaen nedenfor?
Tegn en ring rundt tallet som stemmer med din vurdering av hvert utsagn.

13. Barnet likte å tilbringe tid sammen med deg, Friends lederen.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

14. Barnet syntes det var vanskelig å samarbeide med deg om å løse problemene sine.

1	2	3	4
Ikke i det hele	Litt	For det meste	Veldig mye

15. Barnet opplevde deg som en alliert.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

16. Barnet engasjerte seg med deg i å lære nye måter å håndtere eller mestre følelser.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

17. Barnet var ivrig etter å avslutte terapitimen.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

18. Barnet gledet seg til terapitimen.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

19. Barnet følte at du brukte for mye tid på å fokusere på hans/hennes problemer.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

20. Barnet var motvillig til å komme til terapitimen.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

21. Barnet brukte tiden sin sammen med deg til å gjøre endringer i sin atferd.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

22. Barnet uttrykte positive følelser ovenfor deg, Friends lederen.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

23. Barnet ville helst ikke jobbe med problemer/spørsmål i terapien.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

24. Barnet samarbeidet godt med deg om å løse sine problemer/spørsmål.

1	2	3	4
Ikke i det hele tatt	Litt	For det meste	Veldig mye

Appendix N

SKÅRINGSMANUAL

FOR

TERAPI-PROSESS OBSERVASJONSKODINGS-SYSTEM FOR BARNETERAPI – ALLIANSESKALA

TPOCS-A

Bryce D McLeod (2005)

Oversatt til norsk av Krister W. Fjermestad
Tilbakeoversettelse av Marianne Christensen og
Randi Sigrun Skogstad godkjent av McLeod 2008

I. INTRODUKSJON

Skåringsmanualen er laget for å gi kodere en omfattende veiledning i skåring av behandlingsvideoer med TPOCS Allianseskala (TPOCS-A). Manualen tjener både som støttedokument for å trene opp nye kodere i bruk av TPOCS-A, og som referansedokument for opplærte kodere til bruk ved skåringer. Slik sett inneholder manualen nøye beskrivelser av hvert ledd og gir tilleggsinformasjon for å hjelpe koderen med å kunne ta skåringsavgjørelser på et informert og reliabelt grunnlag.

Manualen er organisert i samsvar med rekkefølgen av skåringsledd i TPOCS-A. Avsnittet med generelle instruksjoner gir en oversikt over skåringsstrategier og fallgruver ved koding for å hjelpe kodere til å oppnå og opprettholde kodingsreliabilitet. Videre gir avsnittene om arbeidsallianse-subskalaen og oppgave-subskalaen detaljert beskrivelse av skåringsleddene. Disse avsnittene er presentert i følgende format:

a) Leddet som det fremstår i TPOCS-A
b) Kort beskrivelse av leddet
c) Supplerende kodingsinformasjon

.

II. GENERELLE INSTRUKSJONER

Dette avsnittet gir en oversikt over retningslinjer for skåring, for å bistå kodere I å skåre behandlingstimer på en effektiv, standardisert og reliabel måte. Kodere bør lese dette avsnittet nøye. Det er viktig å bli grundig kjent med retningslinjene for koding før skåring av behandlingsvideoer.

A. RETNINGSLINJER FOR PROSEDYRE

1. **Skåre klienten og behandlerens atferd.** Kodere skal skåre arbeidsalliansen langs to dimensjoner: 1) Klientatferd (f.eks. handlinger og utsagn) og 2) Interaksjon mellom klient og behandler.

2. **Hyppighet og intensitet.** De fleste ledd krever at koderen skårer hyppighet og/eller intensitet av klientens atferd. Hyppighet er definert som antall ganger klienten utfører atferden. Intensitet er graden av anstrengelse eller krefter klienten legger i atferden når den forekommer. Beskrivelsen av hvert ledd gir retningslinjer for vekting av den relative viktigheten av hyppighet og intensitet. For å avgjøre hvor mye hver dimensjon (hyppighet og intensitet) skal vektlegges for hvert ledd, må kodere basere seg på opplæringen sin, beskrivelsen av leddet, hvor kjent de er med skalaen og sin erfaring med videokoding.

B. STRATEGIER FOR SKÅRING:

1. **Skåre det som "er", ikke det som "burde være".** All skåring fokuserer på klientatferd. Skårere skal bare skåre det klienten faktisk gjør i timen, ikke hva som kunne vært gjort eller burde vært gjort. Et ledd skal bare skåres som positivt dersom leddet på en eller annen måte er representert blant klientens atferd (altså hva klienten gjør eller sier). Her er en kort oppsummering av viktige retningslinjer for å skåre det som "er" og ikke det som "burde være":

a) Skåre bare klientens atferd.
b) Skåre bare hva klienten gjør, ikke hva du tror klienten burde ha gjort, og ikke hva du tror klienten hadde intensjon om å gjøre.

c) Aldri anta eller gjett hva klienten muligens tenker. Hvis der ikke finnes atferdsbevis i form av noe klienten sier eller gjør, så ikke gi det aktuelle leddet en positiv skåre.

2. Å være for kjapp på avtrekkeren: Ettersom leddene i TPOCS-A skåres på globalt nivå, skåres de ikke før man har sett hele timen. Klientatferd som forekommer seinere i timen kan påvirke koderens vurdering av atferd som forekommer tidligere. For eksempel kan en klient som innledningsvis ikke viser positiv affekt overfor behandleren vise mer av dette ettersom timen skrider frem. En revurdering kan imidlertid også foregå i motsatt retning. En klient som viser positiv affekt tidlig i timen kan vise mindre seinere i timen, slik at en tidlig antydning til å skulle gi høye skårer revurderes ettersom timen skrider frem.

3. Å være nøyaktig: Les hvert TPOCS-A-ledd nøye hver gang et ledd skåres, slik at hele innholdet vurderes før en endelig beslutning tas. Ha alltid en manual tilgjengelig når du koder og sjekk med denne hver gang der er tvil om hvordan et ledd skal skåres.

Se gjennom generelle instruksjoner og avsnittene om arbeidsallianse-subskalaen og oppgave-subskalaen med jevne mellomrom etter opplæring. Å se gjennom disse bidrar til å sikre reliable skåringer og beskytter mot "koder-drift" (for eksempel, hjelper til å unngå at kodere utilsiktet innfører sine egne definisjoner og standarder for leddene.) Videre, fordi det å skåre videoer er en krevende og arbeidsintensiv prosess, ikke utfør andre oppgaver mens du skårer.

C. FALLGRUVER VED KODING

1. Å unngå halo-effekter. Kodere må være nøye med å unngå tilfeller av halo-effekter. Halo-effekter referer til situasjoner hvor skåringen av et ledd er feilaktig påvirket av skåringen gitt til et annet ledd, eller av en global bedømmelse av hele timen. Halo-effekter kan komme i ulike former; her er noen relevante eksempler:

a) Koderen bestemmer seg for at hun virkelig liker klienten. Som resultat tenderer hun til å gi klienten høye skårer på alle ledd.

b) Koderen er spesielt imponert over et spesifikt behandlingssegment. Som resultat skårer koderen mange ledd høyt.

c) Koderen observerer tidlig at dersom timen hadde blitt stoppet, ville klienten fått lave skårer. Ved å ha dannet seg en negativ mening, vektlegger ikke koderen tilstrekkelig atferd som forekommer seinere i timen. Koderen gir derfor lave skårer på de fleste ledd.

d) Koderen bestemmer seg for at hun virkelig misliker klienten. Som resultat har hun en tendens til å gi lave skårer på alle ledd.

e) Koderen bestemmer seg med intensjon, eller handler uten intensjon, som om to forskjellige ledd naturlig hører sammen.

For å unngå halo-effekter må koderen følge de konsistente kriterier som er gitt i denne manualen. Koderen må skåre hvert ledd som en separat, uavhengig enhet som ikke er påvirket av andre ledd. Koderen bør grunnleggende behandle hvert TPOCS-A ledd som om det var fullstendig ukorrelert med andre ledd, selv om det kan virke som om det har lignende karakteristika.

2. **Betegn dem som du ser dem.** Husk at ikke ethvert aspekt av arbeidsalliansen kan skåres. TPOCS-A er ingen uttømmende liste av alle arbeidsalliansens dimensjoner. Kodere bør derfor ikke utvide vurderingen av klientatferd for at den skal passe til et av leddene (selv om det ser ut som et potensielt spesielt viktig behandlingsøyeblikk). Når klientatferd tvinges til å passe enkelte ledd (eller omvendt), settes koderens reliabilitet i alvorlig fare.

III. ALLIANSESKALEN

Koderens navn: _____

Dato for behandlingstimen: _____

Klient ID#: _____

Time nummer: _____

Klient: _____

Instruksjoner: Ved bruk av skalaen nedenfor, vennligst indiker din **bedømming** av fire aspekter ved timen du nettopp har sett. Baser alle skårer på timen som helhet. Plasser riktig tall fra skalaen på plassen foran hvert ledd.

1	2	3	4	5	6	7
Ikke i det hele tatt		Noenlunde	I stor grad			I ekstrem grad

_____ 1. I hvilken grad syns du dette var en **god** time?

_____ 2. Hvor **involvert** var du da du så videoen?

_____ 3. Hvor mye **likte du personlig** behandleren i denne timen?

(Ikke ta i betraktning andre timer du kan ha sett behandleren i)

_____ 4. Hvor mye **likte du personlig** klienten i denne timen?

(Ikke ta i betraktning andre timer du kan ha sett klienten i)

DEL I: BOND

INSTRUKSJONER: Ved bruk av skalaen nedenfor, vennligst indiker din bedømming av båndet mellom klienten og behandleren i timen du nettopp har sett. For denne skalaen er bånd definert som i den grad klient og behandler utvikler et forhold som er karakterisert av 1) positiv affekt (for eksempel å like, å forstå, og å bry seg) og 2) gjensidig tillit. Baser alle skåringer på timen som helhet. Sett en sirkel rundt tallet som passer best for hvert ledd.

A. I hvilken grad vurderer du at klienten…

R1. …gav indikasjon på at han/hun opplevde terapeuten som forstående og/eller støttende?

0	1	2	3	4	5
Ikke i det hele tatt		**Noenlunde**			**I stor grad**

BESKRIVELSE: Dette leddet oppfanger til hvilken grad klienten indikerer at han/hun føler seg forstått og verdsatt av behandleren. Klienten refererer kanskje eksplisitt til behandlerens forståelse og støtte (for eksempel ”jeg liker virkelig å snakke med deg, du forstår meg virkelig”), eller indikerer implisitt at han/hun føler seg forstått og/eller støttet ved å ta risikoer i behandlingen (for eksempel elaborere videre på behandlerens kommentarer og/eller avsløre følelser – enten verbalt eller gjennom lek).

Ved skåring av dette leddet må kodere ta I betraktning hvor hyppig og/eller intenst klienten indikerer at han/hun indikerer at han/hun føler seg forstått og verdsatt i timen. En skåre på ”5” indikerer at klienten hyppig indikerer at han/hun føler seg forstått og verdsatt (for eksempel hyppig elaborerer videre på behandlerens kommentarer), **ELLER** intenst indikerer at han/hun føler seg forstått og verdsatt (for eksempel avslører at han/hun har vurdert selvmord).

R2. …handlet på en fiendtlig, kritisk eller defensive måte overfor behandleren?

0	1	2	3	4	5
Ikke i det hele tatt		**Noenlunde**			**I stor grad**

BESKRIVELSE: Dette leddet fanger opp i hvilken grad klienten interagerer med behandleren på en sint eller mistenksom måte. Klienten kan være verbalt fiendtlig (for eksempel ”jeg hater deg”), kritisk (for eksempel ”hvorfor stiller du alltid de samme dumme spørsmålene”) eller defensiv (for eksempel ”hvorfor fortsetter du å spørre meg om det”). Klienten kan også være fysisk fiendtlig (for eksempel kaste ting på behandleren).

Ved skåring av dette leddet må kodere ta I betraktning hvor hyppig og/eller intenst klienten interagerer med behandleren på en fiendtlig, kritisk eller defensiv måte. En skåre på ”5” indikerer at klienten hyppig viser seg fiendtlig, kritisk eller defensiv gjennom timen (for eksempel hyppig sier at han/hun ikke liker terapeuten) **ELLER** virker intenst fiendtlig, kritisk eller defensiv i en del av timen (for eksempel intenst roper at behandleren er en udugelig idiot).

R3. …viste positiv affekt overfor behandleren?

0	1	2	3	4	5
Ikke i det hele tatt		**Noenlunde**			**I stor grad**

BESKRIVELSE: Dette leddet fanger opp i hvilken grad klienten viser at han/hun liker behandleren. Klienten kan verbalt uttrykke at han/hun liker behandleren (for eksempel ”jeg liker deg virkelig”) eller nonverbalt vise at han/hun liker terapeuten ved å smile, le, eller være fysisk orientert mot behandleren.

Ved skåring av dette leddet må kodere ta I betraktning hvor hyppig og/eller intenst klienten viser at han/hun liker behandleren. En skåre på ”5” indikerer at klienten hyppig viser at han hun liker behandleren gjennom timen (for eksempel hyppig smiler eller ler) **ELLER** intenst viser at hun liker behandleren i en del av timen (for eksempel intenst sier at hun virkelig liker behandleren).

R4. …delte sine erfaringer med behandleren?

0	1	2	3	4	5
Ikke i det hele tatt		**Noenlunde**			**I stor grad**

BESKRIVELSE: Dette leddet fanger opp i hvilken grad klienten gav uttrykk for sitt synspunkt til behandleren. Klienten kan gi uttrykk for sin erfaring ved å fritt, åpent og lett snakke om håp, drømmer og meninger.

Ved skåring av dette leddet må kodere ta I betraktning hvor hyppig klienten uttrykker sin erfaring når muligheten gis (for eksempel hvor hyppig klienten deler sin erfaring når behandleren spør). En skåre på ”5” indikerer at klienten hyppig gir uttrykk for sin erfaring gjennom timen og ikke viser motstand mot, eller har vansker med, å uttrykke sin erfaring når behandleren spør. Det betyr at ingen aspekter ved klientens erfaring som man ville forvente er utelatt (for eksempel villig og i stand til å beskrive hva han/hun gjorde i en situasjon, men ikke hvordan han/hun følte).

R5. …virket ukomfortabel I samhandling med behandleren?

0	1	2	3	4	5
Ikke i det hele tatt		**Noenlunde**			**I stor grad**

BESKRIVELSE: Dette leddet handler om i hvilken grad klienten virket ukomfortabel, engstelig eller merkelig i samhandling med behandleren. Klienten kan aktivt si at han/hun er ukomfortabel med behandleren (for eksempel ”jeg føler meg virkelig ikke komfortabel med å snakke med deg”) eller implisitt indikere at han/hun er ukomfortabel ved ikke å interagere fritt. Åpent og lett (for eksempel snu seg vekk fra behandleren, ikke snakke, ikke leke).

Ved skåring av dette leddet må kodere ta i betraktning hvor hyppig klienten virker ukomfortabel i samhandling med behandleren. En skåre på ”5” indikerer at klienten hyppig virker ukomfortabel i samhandling med klienten gjennom timen.

B. I hvilken grad virket behandleren og klienten…

R6. …engstelige eller ukomfortable i interaksjon med hverandre?

0	1	2	3	4	5
Ikke i det hele tatt		**Noenlunde**			**I stor grad**

BESKRIVELSE: Dette leddet handler om i hvilken grad klienten og behandleren har vansker med å interagere fordi de er engstelige eller ukomfortable. Klienten og behandleren kan vise ubehag gjennom ukomfortable muntlige utvekslinger (for eksempel ubehagelige stillheter eller pauser i samtalen) eller ukomfortable nonverbale utvekslinger (for eksempel vansker med å leke).

Ved skåring av dette leddet må kodere ta i betraktning hvor hyppig klienten og behandleren virker engstelige eller ukomfortable i samhandling med hverandre. En skåre på ”5” indikerer at klienten og behandleren hyppig virker ukomfortable i samhandling med hverandre gjennom timen.

DEL II: TERAPEUTISKE OPPGAVER

INSTRUKSJONER: Ved bruk av skalaen under, vennligst indiker din **bedømming** av de **terapeutiske oppgavene** i timen du nettopp har sett. For denne skalaen er terapeutiske oppgaver definert som 1) de terapeutiske intervensjoner behandleren bruker, og 2) klientens villighet til å bruke eller følge behandlerens intervensjoner. Baser alle skårer for denne skalaen på timen som helhet. Sett en sirkel rundt tallet som passer best for hvert ledd.

A. I hvilken grad vurderer du at klienten…

R1. …brukte terapeutiske oppgaver til å skape endringer utenfor timen?

0	1	2	3	4	5
Ikke i det hele tatt		**Noenlunde**			**I stor grad**

BESKRIVELSE: Dette leddet handler om i hvilken grad klienten brukte terapeutiske oppgaver til å skape endringer eller finne løsninger utenfor timen. For å bruke terapeutiske oppgaver til å gjøre endringer utenfor timen må klienten vise at han/hun handlet i forhold til noe som er lært i behandlingen for å forstå og løse problemer (for eksempel ”jeg brukte belønningsskjemaet denne uken for å få sønnen min til å rydde rommet sitt”). Det betyr at klienten må rapportere at han/hun tok i bruk en terapeutisk oppgave utenfor timen.

Ved skåring av dette leddet må koderen først vurdere hvorvidt der er klart bevis for at klienten handlet i forhold til noe som var lært i terapien for å gjøre endringer utenfor timen. Hvis der er klare beviser, må koderen vurdere hvor hyppig **og/eller** intenst klienten bruker terapeutiske oppgaver til å gjøre endringer utenfor timen. En skåre på ”5” indikerer at klienten hyppig bruker terapeutiske oppgaver til å gjøre endringer utenfor timen **ELLER** intenst bruker terapeutiske oppgaver til å gjøre endringer utenfor timen (for eksempel gir en detaljert beskrivelse av hvordan han/hun brukte terapeutiske oppgaver til å gjøre endringer).

R2. …ikke fulgte terapeutiske oppgaver?

0	1	2	3	4	5
Ikke i det hele tatt		**Noenlunde**			**I stor grad**

BESKRIVELSE: Dette leddet fanger opp til hvilken grad klienten nekter å delta I terapeutiske oppgaver. Klienten kan eksplisitt ha neket å delta i terapeutiske oppgaver (for eksempel ”jeg vil ikke leke”, ”jeg vil ikke snakke med moren min om dette problemet”) eller implisitt nekte å delta i terapeutiske oppgaver ved å 1) ikke følge behandlerens oppfordringer eller direktiver (for eksempel leker ikke med behandleren, utforsker ikke følelser), eller 2) forstyrrer terapeutiske oppgaver (for eksempel fingrer hardt på bordet mens behandleren spør ham/henne om følelser).

Ved skåring av dette leddet må koderen vurdere hvorvidt klienten hyppig **og/eller** intenst nekter å bruke eller delta i terapeutiske oppgaver. En skåre på ”5” indikerer at klienten hyppig nekter å bruke eller delta i terapeutiske oppgaver **ELLER** intenst nekter å bruke eller delta i en terapeutisk oppgave i en del av timen (for eksempel absolutt nekter å delta i en bestemt terapeutisk oppgave).

B. <u>I hvilken grad vurderer du at klienten og behandleren…</u>

R3. …jobbet likt sammen om terapeutiske oppgaver?

0	1	2	3	4	5
Ikke i det hele tatt		**Noenlunde**			**I stor grad**

BESKRIVELSE: Dette leddet måler I hvilken grad klienten og behandleren jobber som et team om de terapeutiske oppgavene. Når klienten og behandleren jobber sammen om de terapeutiske oppgavene er samhandlingen karakterisert ved lik innsats (for eksempel behandler og klient viser samme innsatsnivå i forhold til de terapeutiske oppgavene) og responderende utvekslinger (verbale eller nonverbale). For eksempel kan behandleren og klienten elaborere videre på bemerkninger eller hjelpe hverandre med å fullføre terapeutiske oppgaver (for eksempel foreslå følelser, hjelpe hverandre med å bygge et hus).

Ved skåring av dette leddet må koderen vurdere hvorvidt hyppig **og/eller** intenst klienten og behandleren samarbeider om terapeutiske oppgaver. En skåre på ”5” indikerer at klienten og behandleren hyppig samarbeider om de terapeutiske oppavene **<u>ELLER</u>** intenst samarbeider om de terapeutiske oppgavene uten tegn på at enten den ene eller den andre viser mer innsats, eller at de ikke var i stand til å samarbeide. Det betyr at klienten og behandleren ikke går inn i perifere eller overfladiske interaksjoner som ikke er relatert til de terapeutiske oppgavene.